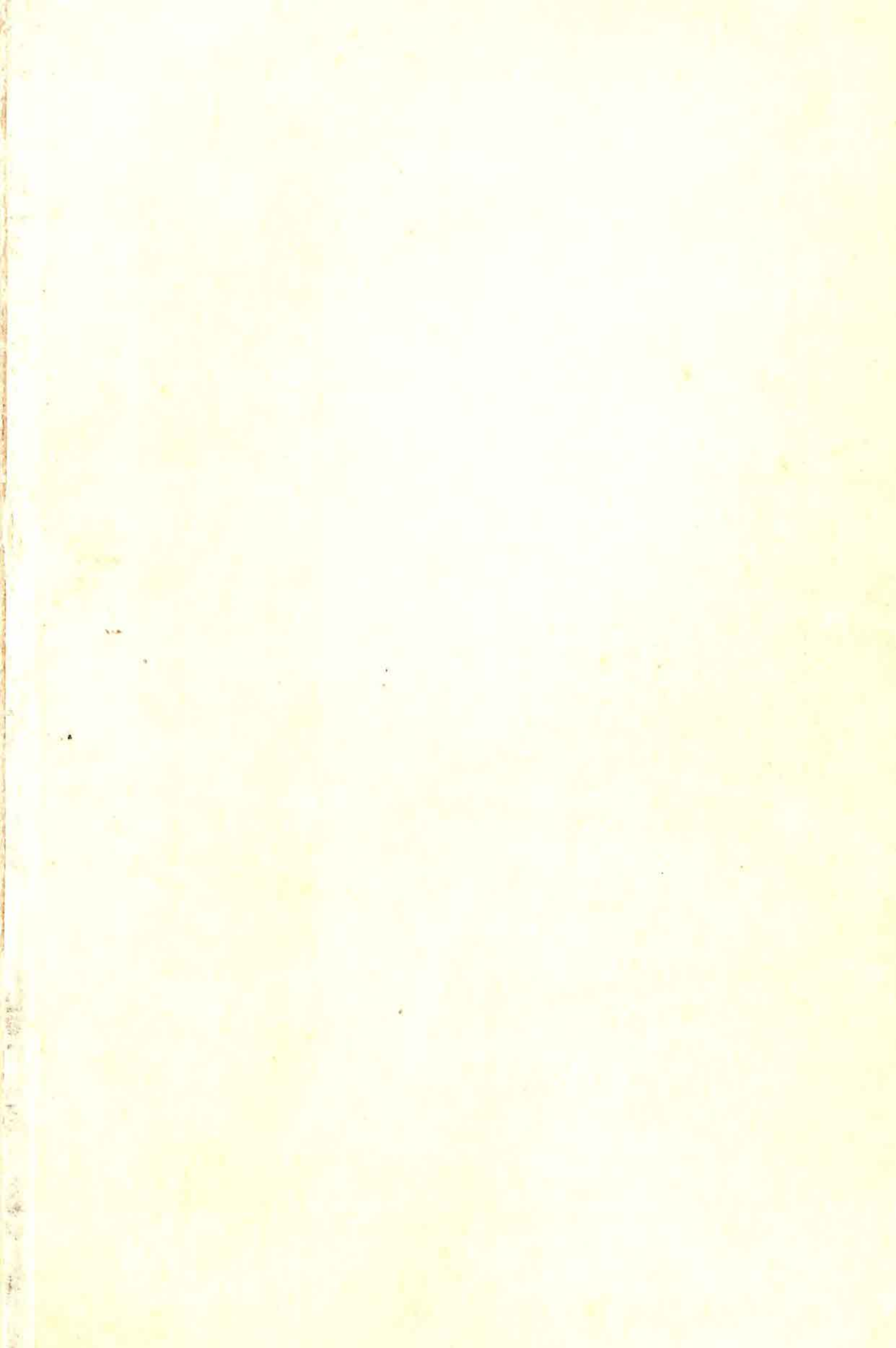


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CLINICAL CHILD PSYCHIATRY

DEDICATION

This work is dedicated to the Commonwealth Fund of America, in grateful acknowledgement of the fact that Child Guidance owes its development in Great Britain almost entirely to the far seeing policy of the fund, more than thirty years ago, in financing the training of professional personnel. The author hopes that the Directors will find in this book evidence that their faith and vision in the past have resulted in the growth of something of value.



A WORLD MENTAL HEALTH YEAR PUBLICATION

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CLINICAL CHILD PSYCHIATRY

By

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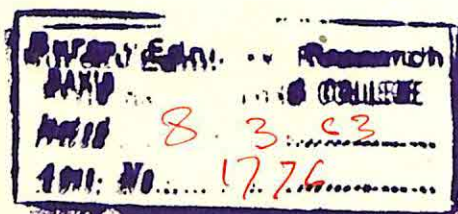
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Preface

CHILD psychiatry owes its emergence as a distinctive medical discipline to the invention of Child Guidance by William Healey and his associates. This, originally, was the team approach of psychiatrist, psychologist and social worker to the problems of juvenile delinquency; and even in this narrow form, child guidance is no more than about fifty years old. The team approach gained in popularity only very slowly and the first Child Guidance Clinic designed for the broader field of children's difficulties was not opened until 1921, in New York. Ten years later, professional training in child guidance disciplines became available in a small way in Great Britain, but it was not until after the close of the Second World War that the movement assumed any nation-wide significance here.

The pioneers in child psychiatry necessarily had to adapt to their new field their experience of adult psychiatry. Professional values have been pragmatic, on the whole; and systems of aetiology and diagnosis have been derived mainly from the psycho-biological and psycho-analytical schools of adult psychiatry. There is not enough generally accepted hypothesis to support a characteristic system of pathology of child psychiatry.

Now that a new generation of child psychiatrists has begun to grow up professionally within the speciality, signs of more truly endogenous thinking are appearing. Having been trained in an interdisciplinary atmosphere, child psychiatrists are now in a better position than their predecessors to temper their clinical observations with the findings of experimental psychology, on the one hand, and with modern advances in sociology, on the other.

The standard literature of medicine has always lagged behind the journals, and books on child psychiatry are not yet reflecting the new clinical attitudes. It has seemed to me that child psychiatry is much in need of the kind of services that Sydenham and a few of his contemporaries rendered to medicine in the eighteenth century by their painstaking, accurate and detailed descriptions of the phenomena of illness. Their contribution to medical knowledge was fundamental. Due to their work, the major syndromes became recognizable by the whole medical profession, the nineteenth-century work of classification and establishment of exact pathology proceeded and, more important still, medical education became systematic.

With this example in mind I have set out to describe what I have seen and

heard while practising child psychiatry, and I have also tried to suggest some guide lines for developing systems of aetiology and diagnosis. The cases of about one hundred children and their families have been selected to illustrate a representative range of problems commonly encountered in child guidance practice. Apart from a few necessary exceptions, I have not dwelt long on the abnormal. The essence of child psychiatry is in the problems of the ordinary family composed of well-intentioned people, who have come to grief over some commonplace situation in which any adult might be placed at some time. Such situations are normal hazards of family life—accidents, illnesses, bereavements, minor incompatibilities, ordinary human error and so on.

The classical preoccupation of the clinician with the organization of the phenomena of disease—the symptoms and signs—in search of a common aetiology and a single pathology has, when applied to childhood, the serious disadvantage of undervaluing the factors of time and sequence of development. I have adopted a different approach and have made time the main basis of classification. Accordingly, I have attempted to group the various aetiological factors chronologically, according to the periods in the children's lives in which the factors appear to have been operating most significantly. Then I have described what I observed in each group of cases. Thus my search for a system of aetiology has been conducted mainly in the dimension of time or, to be more precise, in the field of development.

This method of classification has the major drawback that it is bound closely to culture, in that the cultural pattern will regulate interpersonal relationships and largely determine both individual and group behaviour. Therefore the necessary cultural homogeneity has been sought by orienting this work towards Great Britain or, more specifically, London and the southern half of England. I hope that the greater degree of specificity that this permits will, in the long run, add to the usefulness of the book to non-British readers.

In the case of the young child, the family serves as a placenta in the social matrix. This book has therefore been centred on the family, but with some attempt to gain a sense of perspective of the family in time and place. The discussion has been divided chronologically into periods, in each of which the salient developmental features have been described. The children's unhealthy, disordered and diseased processes have been discussed in a setting of the legacy of difficulties from earlier phases of life and the possible harmful effects of the children's own curative and recuperative reactions.

A comment has been added to the end of each case description, mainly in order to relate the case to the nosological framework that has been set out in Chapter 17, as a tentative step towards a more satisfactory classification of children's psychiatric disorders. My main objective throughout has been to describe phenomena and, if possible, to pick out patterns that may enable the organization of our knowledge to be improved. No particular school of

psychology or psychopathology has been invoked but a psycho-dynamic approach has been used in the interpretation of child development phenomena.

I hope that a dozen years of experience of clinical demonstrations and seminars with mixed groups of students will absolve me from a charge of being too ambitious in planning a clinical textbook not only for post-graduate study by medical men and women who are specializing in child psychiatry, but also for post-graduate study by psychologists and psychiatric social workers in the child guidance team.

All clinical students know that child psychiatry, like other medical disciplines, cannot be learnt at an advanced level solely from books. There is no substitute for the acquisition of clinical and, especially, psycho-therapeutic skills by practice under supervision. For this reason little space has been devoted in this book to clinical techniques. The chapter on therapy is intended only to illustrate some of the principles underlying successful psychotherapy in relation to a selection of the cases described in the text. It does not set out to teach techniques of therapy.

In addition I hope that this book will prove useful to paediatricians, public health doctors, general practitioners and medical students in their clinical years. It is very important for the future of mental health prophylaxis that all doctors who treat children should have at least a general orientation in child psychiatry. I might add that it would well repay the labour of writing this book if, as a result of reading these cases, new entrants to the speciality were to be encouraged to take up the necessary advanced studies.

A third class of reader to which this book is addressed, in part, includes public health nurses and social workers in the school medical, and the maternity and child welfare services, school psychologists, teachers, and other workers with maladjusted and subnormal children. They may find that the case descriptions and comments will illuminate some of their everyday problems.

Finally, I would add that I believe that this book will appeal chiefly to those readers who have had clinical experience with children; and that only those who possess the interest and patience necessary to study a mass of case material collated from a large number of families should be encouraged to read it.

In writing this book I have drawn freely upon the clinical experience of twenty years of work in a team discipline and, therefore, I am deeply indebted to a large number of my colleagues. First, I must gratefully acknowledge my debt to those who introduced me to child psychiatry and gave me my early training, and especially to the late Dr. William Moodie, Dr. Mildred Creak and Dr. John Bowlby. Secondly, I must warmly thank my colleagues at the London Child Guidance Clinic and, post-war, at the Child Guidance Training Centre and at University College Hospital, who

have contributed the case records from which descriptions have been taken. They are too many to list completely but the bulk of the psychological reports were made by Dr. Lucy G. Fildes, Miss Grace Rawlings, Miss Norah Gibbs, Mrs. Margaret Ingram, Mrs. Clare Hyman and Miss Irene Herzberg. The psychiatric social work has been carried out mainly by Miss Hilda Horder, Miss Nance Fairbairn, Mrs. Jean Rhees, Miss Margaret Eden, Miss Mary Turnbull, Miss Mabel Weiss and Mrs. Barbara Dade. The high quality of my source material has been a great inspiration to me.

Lastly, and most important, I owe my wife an enormous debt of gratitude for her encouragement, for undertaking the preparation of the manuscript, and for her devoted work as literary editor. Her collaboration has made this otherwise onerous task a pleasure for me.

KENNETH SODDY
London, 1960

PART I

Constitutional and Environmental Factors

Chapter I

Heredity or Environment?

It is frequently said of a child: 'He takes after his father', or: 'He gets that from his mother.' Commonly one set of adult friends of the family will maintain that the child takes after the father, and another set will maintain that he resembles the mother. A third set will be changeable; and, indeed, it is often striking how a child will suddenly take on the appearance or the gestures of one parent or may resemble both at the same time or in rapid succession.

Whatever may be the state of scientific knowledge of the subject, the ordinary citizen has no doubt about the influence of heredity on physical form. To him the evidence of resemblances between relations overshadows any negative evidence, so that marked family differences and, more so, the absence of any particular resemblances, are largely overlooked.

Though this is not so obvious, the ordinary citizen is scarcely less confident about the inheritance of mental characteristics. The very expressive phrase 'to take after' normally includes physical and mental conformity, impartially. It is a commonplace to remark that an individual possesses 'the family hot temper', liveliness, parsimony, or whatever may be the supposed family trait; though there is no record of experimental attempts to sort children into their respective families, on the basis of observed qualities.

Most scientists, in contrast, display the greatest reserve about the influence of heredity on human physical and mental characteristics. The clinician who interprets only scientific facts of heredity to the parents of his patients has an uphill task, for popular conviction goes further than belief in the direct transmission of character traits to belief in inheritance from collateral branches and includes the influence of former spouses. Dog breeders commonly refuse to breed from a pedigree bitch which has previously mated with a mongrel. German Nazis were superstitious about a 'taint' which the future 'pure Aryan' children of a Gentile mother would bear, because of her previous marriage with a Jew. Similar notions, explicit or implicit, or even unconscious, are common in Britain today, including superstitions about the influence of experiences during pregnancy on the unborn child. The subject is misty and obscured by magic.

What people believe about heredity is as important to the clinician as what is objectively known about it; but the clinician must know the facts. Pro-

fessor L. S. Penrose, Galton Professor of Eugenics, University College, London, has summarized the scientific position: 'Every individual is the product of an interaction between inborn tendencies and environmental influences; each of his morphological characters or his reaction patterns can be examined with the aim of finding either the inborn or the acquired determining factors . . . the contribution of each hereditary factor, however, is not absolute but relative to the total configuration of circumstances of time and place' (1953).¹

THE SCIENTIFIC VIEW OF GENETICS

Modern genetic science, according to Penrose, holds that the manifest characters or traits of an individual are not themselves inherited, but are the end results of causal processes in which genes are significant elements. This is the pre-eminent mode of hereditary influence in human beings. The familial patterns observed in numerous human traits give strong indications of almost complete dependence on single-gene transmission, though, because of the intermediate links in the causal chain the trait may not always be apparent when it is present. Unfortunately for the sake of the predictive value of genetic knowledge, the characters which are of interest from the social and emotional point of view usually are involved with many genes, and the causal chain is equally complicated. Moreover, the very nature of heredity implies a chance selection of half the parental genes for transmission to the offspring.

Penrose summarizes the state of knowledge by describing four classes of knowledge:

1. There is exact information about the inheritance of certain blood antigens ABO, MN, Rhesus, CDE, etc. If a child has an antigen, then one parent must have this same antigen. This knowledge enables no specific predictions to be made but it is recognized that with certain conditions of parental blood incompatibility, extensive damage may occur during foetal life.

2. There is reliable information concerning the familial occurrence of certain recessive or sex-linked traits, especially those causing individual biochemical peculiarities. Some of the rare anomalies involved are associated with serious diseases or defects. Parents are nearly always unaffected, and the incidence of the trait is increased by inbreeding. In a few exceptional cases, carriers of recessive genes can be detected.

In these cases it is sometimes possible to predict the likelihood of occurrences of recessive diseases with onset in later life, but only as a special risk if close relatives are known to have suffered from such conditions—the risk not being more than remote in the case of rare recessive traits. Disease falling into this class includes certain types of epilepsy, nervous degenerations and myopathies; but (according to Penrose) not schizophrenia.

3. The evidence about rare dominant traits is less precise, but good. The

¹ Penrose, L. S.: 'Hereditary Influences in Relation to the Problem of Child Adoption' (1953) *Bull. Wld. Hlth. Org.*, 9, 417.

route of transmission is from parent to half the offspring, but it is often irregular and tends to skip individuals. However, the chance of recurrence of the trait in a close relative is considerably greater than in the case of the general population and cases may arise *de novo*, on account of a fresh mutation. The standard example of a rare dominant trait is Huntington's chorea, the presence of which in a parent implies a 50 per cent. chance that the child will develop the disease at about 35 years. An unaffected parent younger than 35 years who has close relatives affected may also be a transmitter. It is, however, far from established that manic depressive psychosis (cyclothymia) is subject to similar transmission, as has sometimes been stated.

4. Penrose has stated that there is little exact knowledge of the genetics of the common variations in graded polymorphic characters. Eye, hair and skin colours, stature, length of life, personality and mental ability each depend on more than one gene, as do abnormal behaviour traits such as the common psychoses, epilepsy, psychoneurosis and mental deficiency. There is probably a large number of steps between any given gene and the emergence of a quality which is of social interest; and an additional complicating consideration is the varying social criteria which are applied to behaviour patterns.

With the receipt of half its complement of genes from each parent, the offspring will have the same average value of graded traits, though children may deviate far above and below the mean parental level. Moreover, most of these common polymorphic traits are greatly influenced by environment, of which it might be held that a kind of average is transmitted to the child by the parents. Thus it is usually difficult to separate genetical from environmental sources of variation in these traits; and the information gained from studies of monozygotic twins will demonstrate only the minimal possibilities of environmental modification. Moreover, monozygotic twin pairs are themselves anomalous in their susceptibilities to the effects of environmental influences.

THE POSSIBILITY OF FAMILIAL LIKENESSES

It is legitimate only to postulate that there will be a definite degree of likeness—though subject to variation—between parent and child. Even the stature of the child may differ from that of the parental mean, though, commonly, children grow as tall as the parent of the same sex. Parents of able intellect are likely, but not certain, to produce clever children, and morons likely, but not certain, to produce dull offspring; and the intellectual level to which a child develops may be influenced by the environment. Character, though subject to the same general rules, may come even more under the moulding influence of the environment, and so, too, may the common psychiatric disorders.

Penrose has also pointed out that, while hereditary constitution may set

limits to individual development, it is equally true that the limits are set only by the rigidity of the environment.

So much for exact knowledge about heredity in the human child. Emphasis in the psychological world in Great Britain and in the U.S.A. has shifted away from hereditary on to environmental causes of variation during recent years, but in Scandinavia the genetic approach is still widely favoured. In the English-speaking countries, indeed, heredity has almost been forgotten in the general interest aroused by the work of Bowlby (1944),¹ and (1951),² Spitz (1945 and 1946),³ and others on the connection between later personality formation and babies' early experiences of love relationships.

Because of the slow turnover of human generations and the complexity of the subject, knowledge of human genetics must inevitably grow slowly. The very nature of genetic principles, moreover, with chance selection of half the genes of each parent for transmission to the offspring, makes it a matter of surprise that as much family likeness exists as there seems to be. It is impossible to distinguish exact observations from unchecked generalizations in this field.

CONSTITUTION AND HEREDITY

It is a popular belief that, in human mating, opposites are attracted to each other but there is no evidence that this is true in the case of mental characteristics. It is obviously untrue in the case of some aspects of personality like intelligence. Perhaps what matters most in human mating is congeniality of qualities. Congeniality is a complex matter which may depend mainly on the attitudes to, and types of, love relationships of each partner, and in determining these, personal history, rather than heredity will probably be dominant.

Inasmuch as constitution exercises an early influence upon the kinds of relationships that a baby will form, congeniality may have some slight association with heredity. The likelihood of offspring possessing such a 'pseudo' hereditary disposition to form relationships similar to those of their parents may, in its turn, be enhanced by the community of outlook between the parents. These factors will combine strongly in favour of likeness between succeeding generations of the same family; and the common pattern of life and social experience extending over two or more generations will augment those influences.

Constitutional forces in favour of like parent—like child will not prevent

¹ Bowlby, J.: 'Forty-four juvenile thieves, their characters and home life' (1944) *Int. J. Psycho-Anal.*, 25, 107-127.

² Bowlby, J.: 'Maternal Care and Mental Health' (1951), *W.H.O. Monograph Series*, No. 2.

³ Spitz, R. A.: 'Hospitalism' (1945). *The Psychoanalytic Study of the Child*, I, p. 53. Spitz, R. A., and Wolf, K. M.: 'Anaclitic depressions', *The Psychoanalytic Study of the Child*, II, pp. 313 *et seq.*

the common occurrence of differences and even antipathy between parent and child; but marked differences can usually be traced to environmental factors of which the attitude of the parent is commonly the most important.

Although there may be general agreement about the likelihood of similarity of nature and disposition among the members of the same family, public interest fixes too strongly upon evidence of similarity when it occurs, is excited by occasional examples of marked difference, and largely ignores the common instances of children being neither particularly like nor particularly unlike their parents. In a patrilineal society, a remark like 'the Robinsons all have hot tempers' indicates uncritically accepted assumptions and incomplete observation, since the distaff side has been left out of account.

Modern advances in electro-neurophysiology have opened up possibilities of understanding aberrant electrical brain rhythms in young babies that may throw light on these difficult problems of inheritance; but before much understanding is gained, a great deal more must be found out about intermediate stages between brain rhythms and their connected patterns of behaviour.

THE PRACTICAL IMPORTANCE OF STUDIES IN HEREDITY

Two aspects of heredity are of immediate concern to the clinician: the connection of heredity with basic patterns of temperament; and with the child's capacity to form relationships during early infancy.

Most schools of psychology concerned with human personality have a common denominator in their division of temperament into primary types along the lines of introversion and extraversion as described by Jung. No attempt will be made in this work to classify temperamental types in order to satisfy everyone but instead, for working purposes, a simple distinction will be made between the life patterns of those people whose natural tendency it is to turn outwards into contact with human beings and other objects in their environment; and those who, by nature, tend to withdraw into themselves. In order to avoid any misconception that to adopt this basic principle implies identification with Jung's established system of typology, the terms 'out-turning' and 'in-turning' will be used.

New-born babies also differ considerably in their reactivity to variations in the environment. For example: babies' motility varies from hyperkinesis, or continuous, unorganized muscular movement which encroaches upon sleep and continues even during feeding; to hypokinesis, the behaviour of sluggish, 'lazy' babies who have to be roused from their lethargy in order to feed and who may be consistently retarded in the new attainments by which their development is recognized. However, hyperkinesis does not imply greater responsiveness, nor hypokinesis withdrawal; in fact, a direct causal connection between the type of kinesis of the newborn and their tropism in relationships is yet to be established.

Once a typical pattern of reactivity in an individual baby becomes established, traces will remain throughout life, though suitably modified for later times and capacities. 'Overactivity' or 'laziness' in a baby will give pointers to the child's behaviour in the future, whether or not there is also some association between overactivity and the quality described as 'out-turning', and 'laziness' with 'in-turning'. More likely these are two separate scales of variation of behaviour; one, perhaps, more concerned with quantity and the other with quality of behaviour.

The concept of bimodal variations in both quality and quantity of human behaviour opens up the possibility of tracing a connection between patterns of new-born baby behaviour and the in-turning and out-turning differences to be found among adults. It is generally agreed that most people are sufficiently consistent in the degree to which they are out-turning or in-turning for their dominant pattern to be noticeable; but that it is usual for the individual to show both tendencies. When the uncommon example occurs of an extreme or 'pure' type, the result is striking.

If qualitative and quantitative scales of variation exist concurrently, the concept of active or inactive in-turning, and active or inactive out-turning temperaments, respectively, may help in predicting the future development of children. But before reliability can be attained much more exact information is needed about the interactions of these supposedly varying traits, at all levels of development.

In the present state of knowledge, only generalization can be attempted. It is obvious that some people have abundant energy and display ceaseless activity in all sorts of situations; while others are, comparatively, very inactive. On the other hand it is often difficult to compare the quantity of activity of two persons whose habitual behaviour is as different as that of people of extreme out-turning and extreme in-turning temperaments. There is no great difficulty in the case of the active out-turning temperament; such a person is hypomanic, hyperkinetic and displays ceaseless activity. If less active, he will appear to be an open, easily accessible, relaxed person whose life is filled with minor activities which he pursues without excessive enthusiasm.

It is altogether more difficult to assess the quantity of activity of people of in-turning temperament, for their activity is intrapsychic rather than external motor. Some dreamers are productive, but non-productivity is not necessarily inactivity. Some inactive in-turners are comparatively accessible, are little absorbed in their intrapsychic life, but show a conspicuous absence of initiative in making interpersonal contacts. Other people of in-turning type present, as it were, a barrier to the world and give the impression that they fly from contact. This behaviour needs to be distinguished from the restless distractability of some actively out-turning people who fly from one contact into another and thence into a third. Active in-turners may be distinguished

by their withdrawal, their apparent self absorption, and the difficulty which others experience in social intercourse with them.

Although the development of a hyperactive baby into an active, out-turning adult can easily be traced, it has not been possible to trace the development of hyperactive babies into any in-turning reaction pattern. The idea is speculative but, if established by observation, would greatly clarify the typology of young children.

Out-turning and in-turning reaction patterns can be distinguished from the time of the child's first relationship formation, i.e. from about the fourth month onwards. Once established they tend to stay throughout childhood, though subject to many influences modifying the actual behavioural phenomena. Patterns of behaviour that are so fundamental and so all-pervading are likely to be of hereditary, or inborn, temperamental origin.

The second practical respect in which heredity concerns the clinician at this period is the influence that it may exert on the primary relationship formation of the child. This influence cannot properly be separated from that of the child's basic reaction pattern and may be determined by the latter. The nature of the child's resulting relationships can affect, specifically, the later habitual behaviour of the child.

HEREDITARY CAUSES OF POOR RELATIONSHIP FORMATION

Pending fuller discussion later at appropriate points in the text, only general observations will be offered here. That severely mentally subnormal children may have difficulties in relationship formation will be obvious; the profound idiot has no relationship with his environment, and lesser degrees of deficiency will cause impaired relationships. Less obvious is the impairment of relationship formation that may occur in some babies with serious difficulties in early orientation, but without signs of other deficiencies. Such babies fail to conform to the normal rhythms of baby life; which failure, in the absence of damage or disease, can be ascribed only to heredity. Mentally subnormal children will show generalized backwardness, including retardation in emotional relationship formation; but children with difficulties in orientation may show specific failure limited to relationship formation. This will not be a simple disorder, for so much of the child's attainments and faculties will depend upon the quality of relationship formation. But careful analysis of the child's behaviour will show that the child's skills and attainments are not so much retarded as applied anachronistically.

An extreme temperamental type will naturally affect relationship formation. Markedly out-turning babies will react immediately to any and all forms of environmental stimulus. The disadvantage of the out-turning pattern is that of lack of discrimination and impermanence of response. On the other hand, a markedly in-turning baby is subject to the converse dis-

advantage that few environmental stimuli will get through, and weak responses will result.

When, as may easily happen, a very out-turning mother has a similar baby, the effect on the baby's ultimate temperament and character formation will be reinforced. The baby's hazard will be failure to form specific and durable relations with any single person and thus failure to get to understand others. Conversely, a markedly in-turning child of a similarly in-turning mother will receive few environmental stimuli and give few or weak responses, and may form no relationships, nor come to understand others.

In these ways vastly different styles of behaviour can result from similar causes operating in opposite directions upon different temperaments. If the mother is unable to provide for the child's needs for a stable relationship, great maternal anxiety may develop and compensatory tendencies may arise in the child that may cause psychotic forms of behaviour, of an out-turning or in-turning type. These will be discussed later.

The less likely event of a markedly out-turning mother having an extremely in-turning baby may also result in serious difficulties in relationship formation. Whereas the out-turning mother may communicate easily with the child at an infantile level, the weak response of the latter will almost certainly frustrate her; and if she reacts with anxiety the child's in-turning reaction pattern may be augmented.

On the other hand, in the case of the in-turning mother and out-turning baby, it is the latter who will suffer frustration of and possible eventual poverty of basic human relationship formation.

SOME INDIRECT EFFECTS OF HEREDITY

Some difficulties in relationship formation will have a cumulative effect. A baby with a moderate degree of hereditarily determined difficulty in forming relationships may be handicapped at each successive phase of childhood by the effects of incomplete attainments during the last. Any slight hereditary difficulty may thus be greatly augmented, and what is essentially trivial may become a serious handicap.

'Pseudo' Heredity. In the case of older children it is important not to overlook the effect upon the habitual behaviour and, indeed on the child's character, of the common life and community of outlook of the family. In a very direct way, parental attitudes can 'infect' their children. The result may be that the children will 'take after' their parents in a way that gives a greater degree of identity of outlook than any that is conceivable from heredity alone. This 'pseudo heredity' may easily be mistaken for a genuine effect of inheritance.

Bowlby¹ has emphasized the 'circularity' of problems of poor relationship formation. For example, the mother whose own childhood relationships

¹ See footnote, p. 6.

were poor will be prone to allow breaks to occur in her care of her own infant and the child's capacities to relate himself to others may be damaged.

THE UTERINE PERIOD

In the foregoing discussion of heredity, only strictly genetic influences have been included, that is those operating before the formation of the foetal blastosphere. Factors operating during intra-uterine life, sometimes loosely referred to as 'congenital', have been treated as environmental and included in Chapter 4.

EARLY CHILDHOOD

After the birth of the child it becomes difficult to distinguish between the effects of heredity and environment, except to some extent by methods of controlled observation. In considering the interaction of heredity (including pre-determined growth patterns) and environment (including parental child rearing practices) an analogy taken from somatic embryology is useful.

It is a theoretical construct of embryology that before a new development can take place there must be present at the same time:

1. a constitutional pattern of growth;
2. an existing basis on which new development can take place;
3. nutrition to sustain growth; and
4. an 'activator', or biochemical enzyme.

For example, a human foetus will not develop a hand unless (1) this be constitutionally possible; (2) a limb bud is already at the appropriate stage of growth; (3) the necessary amino-acids, minerals, calories, &c. are available; and (4) the activator is present at the proper time.

Lack of any of the four ingredients of development will inhibit growth, and deficiency will cause distortion. Moreover, the four factors must be present together within a short span of time.

This analogy can be applied to psychological development, in principle.

1. Psychological development, no less than somatic, is dependent upon the presence of an inborn constitutional pattern.
2. Psychological development cannot take place on a basis of nothing. For example, capacity to love other human beings is an essential human property which the child cannot develop unless it has first developed the capacity to perceive and to conceptualise the existence of others.
3. Nutrition is also essential, in an analogical sense. In the case of our example, no child can perceive or conceptualise other people unless others are present in the environment. In other words, the child must have psychological experience on which to work.
4. Finally the activator: the child cannot proceed with the development unless it comes to him in an acceptable form; and this is the main role of maternal nurture. If the other individuals, in our example, are pre-

sented to the child in such a way that the former are incorporated into the child's system of instinct fulfilment—but not otherwise—the child can develop the capacity to love. The mother's handling of the child is the pre-eminent 'activator'.

In these four cardinal principles of psychological development the factors of heredity and environment become inextricably mixed. No hereditarily determined development can come to full fruition unless the environmental conditions are optimal; and no socially required development can take place unless the constitutional pattern of the child allows for it. Some of the clinical implications of these considerations will be discussed further in Chapters 4, 6 and 7.

CONCLUSION

In the present state of knowledge, scientific genetics does not offer information of sufficient precision or reliability to enable it to be applied to practical clinical work. Strict science does not go further than the modest prediction that there exists a tendency for children to inherit a mixture of parental qualities, but that in any specific respect children may be above or below the parental average. The life in common of the family tends to increase similarities and reduce differences between parents and children.

There is a danger in clinical work that the importance of heredity in many of the more serious psychological disorders may be underestimated so long as the ultimate link in the causal chain, the link that determines the particular course of the malady, remains unknown.

Chapter 2

The Human Family

It is a commonplace to observe that the family is the one great universal human institution. In all eras and in all human societies human beings have lived in families. The family is far more than merely a device to give children security during their minority, for it is the matrix of society, in which people spend their entire lives.

At various times and in various places the family structure of society has been destroyed by natural disaster or human agency; but in every instance when this has happened the family has been reconstituted after no more than a brief interlude.

The universality and persistence of the family denote its great importance to human society, and indicate that the social and psychological forces protecting the family as an institution are very powerful. Of the numerous social institutions that maintain the stability and continuity of the family the most important, obviously, is marriage.

MONOGAMY

All civilized and nearly all primitive cultures practise an enduring form of marriage, and it is a remarkable fact that in the case of civilized cultures, the majority have shown, overwhelmingly, a preference for life-long monogamy. Among European peoples monogamy has been the rule for something like 4,000 years, since the time of the group marriage of the pre-Hellenic Greeks. And even group marriage implied a life-long kinship not unlike that found today among some South Sea Islanders and isolated Asian hill peoples.

The importance of monogamy to humanity has not been seriously challenged by the polygamy of Islam which appears to have arisen out of conditions peculiar to Arab demography and which has led to female subservience that has created a vicious circle. In spite of this, polygamy as an institution has been dependent for survival on religious sanction, as the experience of Turkey has shown. Even in countries with strong sanctions in favour of polygamy, the majority of men prefer monogamy; not more than one-quarter, and in recent times one-tenth, of all marriages being polygamous. In the case of the polygamy practised in limited classes of orthodox Chinese and Indian society the concept of family is different from that of the monogamous family.

INCEST TABOOS

The stability and durability of the monogamous family might indicate that marriage is protected also by strong natural laws of human sexual behaviour; but surprisingly there is only one such law of universal validity, viz. the prohibition of mother-son incest. As far as is known, no culture has ever allowed mother-son incest, but many peoples have been tolerant about father-daughter and sibling incest. For example, in ancient Egypt and among many modern primitive cultures sibling incest has been a privilege by which royalty has been distinguished from the common people. Even among the twentieth-century British, these 'lesser degrees' of incest, though illegal and thoroughly disapproved, cause far less horror than that caused by mother-son incest. They are protected by nothing like the wall of horrified secrecy that will conceal mother-son incest even from the psychiatrist. Fathers and daughters, and siblings often appear to suffer little from their incestuous experiences; but mother-son incest is encountered only in the case of grossly psychopathic individuals (or else the guilty secret is too well guarded to become known) and has a most corrupting effect on character.

THE WEAKNESS OF INSTINCT IN HUMAN FAMILY LIFE

This single, tremendously strong, universal sexual taboo serves the essential biological purpose of ensuring that young men form their own sexual love relationships. Apart from this instance there is no other important respect in which *unmodified* instinctual drives mould or dominate human family life. Instead, family life is moulded by an enormously complicated flux of instinctual drives modified by environmental experience and passed down the generations in the form of the cultural pattern.

CULTURAL INFLUENCES

The study of child psychiatry is part of wider studies of culture, but in a single volume only general remarks can be made about the distinctive features of British or more specifically, English culture.

The style of family life in a community is determined mainly by recent history—the experience of living members of the community, particularly of the types of relationships formed in their own childhood. Physical circumstances are also important, e.g. the mode of livelihood of the community, the amount of movement, nomadism or colonization, and so on. In European history there has been a shifting balance between male and female influences in the family, within the general state of dominance of the male.

THE EVOLUTION OF MARRIAGE

European mythology reflects the probability that group marriage, i.e. a common sexual life within a narrow kinship system, preceded a system of lasting, particular, interpersonal relationships in marriage. The variegated sex

life of the Greek gods in their earlier days was that of a society in which group marriage was normal. These myths reflected the mores of a settled Bronze Age community living by agriculture and hunting, and given to inter-tribal wars. The balance of power inclined towards the women because the men were expendable, while the women remained as the focus of loyalty of the younger men. The long struggle by Zeus for male supremacy reflected successive Hellenic invasions. Conquest, movement and colonization are incompatible with group marriage. Monogamy supplanted group marriage and established a masculine predominance suited to the physical requirements of the epoch. The persistence of this social institution through more than 3,000 years in Europe has engendered strong psychological forces to maintain it.

PARENT ORIENTATED AND SIBLING ORIENTATED SOCIETIES

Supersession of the matriarchy has not resulted in an unchallenged patriarchy. Throughout European history can be seen the strands of rivalry between paternal and sibling systems of dominance. The classical Greeks favoured the latter and evolved a limited democracy, of government by equals within a restricted patrilineal kinship group. In ancient Rome practical difficulties of democratic organization caused the sibling system to fail as the political unit expanded. It was supplanted by a parental orientation that spread over much of Europe and lasted for nearly 1,600 years. Christianity which became dominant in Europe at the height of the influence of this patriarchal, hierarchical organization of government and family, appears to have adopted the prevailing organizational form of the age.

The ancient imbalance between parent and sibling orientated systems re-appeared in open division during the sixteenth century, and this is usually ascribed to the rediscovery of classical history. It is a remarkable fact that sibling orientation re-emerged mainly among those people of Germanic origin whose ancestors were never completely subjugated by Rome, and on whom the patriarchal and hierarchical system had been incompletely imposed from without by the political power, and subsequently maintained by the religious authority.

English society appears never to have been truly hierarchical, in spite of an imposingly titled aristocracy, and only to a limited degree patriarchal in organization. The Anglo-Saxon and Danish inhabitants of Britain had a form of sibling orientation under the leadership of a parent figure who was subject to deposition. The Church's alien hierarchical organization to some extent provided for the father-dependency needs of the society and by so doing may have relatively increased the sibling influence upon family life. Except that the position of women seems to have declined in comparison with Saxon standards, the patriarchal and hierarchical form of the family and political life of the feudal Norman conquerors of the eleventh century left

remarkably little trace in the family life of the middle English that emerged in the fifteenth century. Curiously, a hierarchical family pattern has lingered on in the numerically minute group of landed, aristocratic families, reinforced by newly arisen industrial tycoons of the nineteenth century, and has exerted a strong influence through the idealized fantasy of family life which has grown up around it. This pattern is no more truly representative of English family life than is that of the problem families of the industrial slum, but its much-publicized influence has exacerbated a feeling that 'things are not what they were'.

THE ENGLISH CULTURAL PATTERN

English social life is complex. Although a newcomer to civilization by classical standards, the political organization of England has been continuous and uninterrupted for nearly 900 years—the longest unbroken tradition of any country in the world. Nearly 900 years of freedom from alien domination has engendered an attitude of political security notably absent in most Continental European countries. Neither during the Napoleonic wars, nor during 1940–41 when exposed to serious threat of invasion, could the British people take the danger of their position seriously.

There are numbers of paradoxes in the English cultural pattern. It is an aristocratic society, yet intolerant of authoritarianism; class conscious but with a strong natural sympathy with the underprivileged; based firmly on spiritual values, yet not outwardly religious; encouraging individualism yet conforming to a general mode of conduct. Though anti-authoritarian, English society is essentially law abiding and responsible. Apart from political struggles of the fifteenth and seventeenth centuries the total loss and damage to life and property due to riots and civil commotion in England in 900 years, has been less than in some 10-year periods of some of its Continental neighbours.

The history of religious, political and family structure in the British Isles has reflected the struggle between parent and sibling dominance, for a hierarchical structure of family life was not native to the Anglo-Saxon and Danish part of the racial inheritance. When a sibling orientation of society emerged, it required for its maintenance, as always, strong mechanisms of inhibition of sibling rivalry; and of these, mutual respect and tolerance are the most important. These values therefore have been particularly important in English life and they will affect the parent-child relationship quite specifically.

The English are famed for compromise, and the compromise that exists between the parent figure and sibling-orientated authority is characteristically English. The father figure is an important symbol, that attracts the respect and affection of the sibling group, but the real power rests with the adult siblings—and both parties are adjusted to their relationship. The result in

political life is a limited monarchy in which the Crown exerts a strong influence but no executive power. The system accepts a hereditary aristocracy, influential but powerless; and though the abolition of the hereditary House of Lords, as an anachronism, has been freely discussed for nearly a century, the proposal attracts little popular support.

In religious organization, the parental-sibling balance has been precarious since the overthrow of the patriarchal hierarchy in the sixteenth century. The Established Church of England was the 'typically English' solution—the retention (by a majority of one vote in the Synod of the time) of the father symbol in the episcopacy and its agents, the parish priests, but with the real power in the hands of the local laity. In nothing has this shown more clearly than in the matter of confession, which is quite voluntary.

This solution satisfied neither the sibling revolt, nor the dependency needs of ordinary people at a time when literacy was a privilege of the few. The Dissenters, having rejected paternalistic authority, did not, in the majority, have sufficient capacity for abstraction to conduct their relationship with God without an intermediary agency, and had recourse to sacred writing.

It has been said as a jibe that Protestants rejected the authority of an infallible Church in favour of an infallible Book, and the Bible has had an incalculable influence on British family life in the direction of making the moral responsibility of the individual less to a father figure than to the abstract standards of the Scriptures. When the Church is the mentor the father figure can dispense forgiveness and the individual may be glad to give up sin and error so that good relations may be restored; but when the Bible is the mentor there is no escape for the individual from his responsibility for his own conduct. Reliance upon biblical authority results in emphasis on morality, on super-ego development, and requires emotional maturity and more complete resolution of childish dependency needs in the individual.

The English compromise between father domination and sibling self-determination is thus reflected in religious and political forms that have themselves tended to weaken paternalistic influence and increase individual responsibility.

An essential point is that, although power is in the hands of the sibling group, the father remains a benevolent figure—provided he accepts the limits set to his influence. The monarch is loved but limited; the aristocracy is respected but ignored in important matters. Strong individualism and enormous emphasis on personal liberty go together with a strong sense of conformity to accepted patterns of behaviour and absence of riots and civil disturbances. Provided he is free to make up his mind and however opposed he may be to the Government, the Englishman is loyal to authority and well disposed towards it. Because authoritarian concepts represent a paternal encroachment upon the sibling position, the English reject the notion that there can be but One True Way of Life whether in religion, social life or politics.

But equally, because revolution and iconoclasm represent an encroachment of siblings upon the legitimate though restricted rights of the patriarch, the English are traditionalistic and mistrust sudden change.

However, there are tensions within the sibling position, and in order to reduce rivalry and increase sibling solidarity great emphasis is laid on unity, corporate spirit and team work. It is no accident that competitive team games have largely originated and shown their greatest degree of development in England. In team games sibling rivalry is controlled and employed constructively. The effectiveness of these devices is seen in the political world where opposing parties may rage at each other but will have confidence that the other will not seize power and maintain themselves by force. In the religious world, the Ecumenical movement expresses sibling solidarity; while, in the opposite direction, there is some turning towards the patriarchal hierarchical system of Roman Catholicism among those whose dependency needs are unsatisfied by the modified sibling system evolved by the English.¹

With the enormous industrial expansion of the nineteenth century the culture favoured a *laissez-faire* attitude which promoted competition. The resulting rise of industrial 'barons' reinforced the hierarchical remnants in family organization, concentrated great power in the hands of a few, but also brought traditional corrective forces into action. Sibling solidarity led to the working-class movement—the emergence of the 'two worlds' of which Disraeli wrote with such feeling in the mid-Victorian era. At first this movement was anti-patriarchal, but it did not, as in Russia two generations later, lead to annihilation of the patriarchy and complete sibling dominance (though some patriarchal features reappeared in Russian political life almost immediately). The English feeling towards the father figure deflected revolutionary currents into an adaptable compromise with the patriarchy, and in due course the working-class party has assumed its share of government under a limited monarchy, in a two-chamber system in which the upper chamber is aristocratic and patriarchal. Compromise could scarcely go further.

Interestingly, the current demand for a so-called Welfare State is an economic consequence of the unsatisfied dependency needs of the people, analogous to the more limited but similar religious movement. In considering this, however, other results of the industrial revolution must be noted.

¹ This is a widespread impression supported by the annual publication by the Roman Catholic authorities of figures of conversions and by the publicity given to the conversion of people who are in the public eye. However, in 1960 the Church of England, for the first time, published comparable figures which showed an average of 14,775 adult conversions annually over the years 1954–56, as compared with the Roman Catholic claim of 12,506 conversions annually over the same period. It may be, therefore, that this supposed tendency is not significant.

THE 'BREAK-UP' OF THE FAMILY

Although the English family has never been strictly patriarchal, in a settled agrarian society free from external danger an extended kinship family system could be expected. The industrial revolution was accompanied by a fivefold increase in population and an enormous volume of migration, both internal and external. The facility with which this happened indicates how easily young adults of both sexes could assume independence. In London the prevailing style of family life is the simplest biological or 'nuclear' unit; only in a small minority of families will three generations live in close proximity and collaterals rarely will. London people do not usually live near their work; suburban development has spread centrifugally from the empty nucleus of inner London. An exception is dockland, where some dynastic families remain, even today, but there, too, wartime bombing has accelerated population movement. Family dispersal has been very considerable in industrial areas also, and only in the small country towns is there left a significant remnant of wider kinship groups. These bear a loose organization which is far from hierarchical in character. In rural areas, the even spread of the population over the countryside has limited the closeness of family contact, which is also being steadily reduced by migration from the country into the towns.

This fragmentation of the English family has not been catastrophic, because of the very looseness of existing family ties. Social change has evolved, and the British people have developed a culture of change which allows of adaptation to rapidly changing conditions without social disaster. It might be claimed that the culture of change is a British invention, and it is noteworthy that the first country to experience the industrial revolution was also the country with the longest history as a continuous political and social entity.

Ancient history has shown that rapid change can be met by a sibling organization, provided that the unit is reasonably homogeneous; but change that threatens to get out of control in the sibling group augments tendencies towards a more hierarchical dependence. Change that becomes stabilized by hierarchical organization will show a lasting quality of rigidity.

Anthropological studies suggest an association between the existence of a rigid, unchanging cultural pattern and the cultural practice of the rearing of young children by their grandparents, as often happens in static societies. Children brought up by grandparents will be prepared for life 20 years in the future by attitudes developed 40 years in the past. In England where, since 1750, change has occurred with increasing momentum, responsibility is passing increasingly early into the hands of young adults. In the U.S.A., which is equally subject to rapid change, the passage of responsibility has been the object of social devices, for instance, the teaching of civic and national responsibility in the High Schools. In Britain, where change is more

intrinsic and less subject to external devices, families have tended to expect more of their children at even earlier ages. This has demanded a high level of personal responsibility in the young citizen that is unknown in a parent-dominated society.

It may be concluded that the 'break-up' of the family has been no such thing in England, but rather a trend of social evolution that has both caused and itself been caused by the 'break-up'. Moreover, the English family has never had the hierarchical form of which the loss is deplored by some, today.

DIFFICULTIES IN A 'CULTURE OF CHANGE'

In a temperate fertile country like England the daily and seasonal agricultural rhythms and biological cycles used to give great security. In contrast, the artificial bustle of the teeming factory town required every power of adjustment of the individual for successful adaptation. The vigorous sibling independence of traditional English family life enabled the first generation to make the adjustment so well, indeed, that the process snowballed to gigantic proportions. Unhappily for the country, the benevolent independence with which the father figure was regarded by the sibling group resulted, among the latter, in an undemanding attitude towards authority. Government lagged—terrible conditions developed, large tracts of country were despoiled, but there was little urge for redress among ordinary people. The prolonged resolution of this situation by orderly change and compromise is recent British history.

Those whose childhood dependency needs had never been fully resolved, fared altogether worse, for they were bewildered by changing conditions. Perhaps worse for them than the loss of accustomed rhythms of life was the loss of daily contact with parents. Naturally their dependency needs were increased.

During rapid change the old established forms will either be swept aside or will themselves undergo modification, which will inevitably lag behind the changes in the cultural life. Resulting tensions may arouse feelings that 'things are not what they were'. When the influence of the parent figures declines the situation will require a greater degree of autonomy of the individual; which may start a tendency towards the preservation and reinforcement of old forms and traditions. In this way, declining parent figures may become more abstract and may regain their influence in the form of tradition, but more remotely related to the individual.

A child's capacity for autonomy will depend mainly upon the quality of the child-parent relationship built up in the first two years. In the case of these families displaced from country to town and out of contact with grandparents and with biological rhythms, warm and close child-parent relationships are essential for mental health. Tradition can make little impact on a child until he is able to deal in abstractions, which will not be before, say, 8 years of age.

In English family life there may be potential tension arising between the child's need to gain autonomy quickly and the parents' uncertainty about how to help him. Such tensions have led to the over-evaluation of and excessive dependence on the more abstract values of tradition, and hence to emphasis on so-called 'character building' through school and community organizations. Interestingly, the British compulsory school entry age is the youngest in the world.

The 'culture of change' contrasts sharply with a fixed externalized cultural framework in which nothing can happen to a young child except in a prescribed form. Though the formal cultural pattern may result in a relative absence of psychological and behaviour disorder, of tension and of extremes of all kinds, it may also result in lack of ability to adapt to changing circumstances.

The fact that strong traditional forces are operating indirectly on the young child needs to be remembered constantly in dealing with British children.

THE 'WELFARE STATE'

In the enormous industrial expansion of the nineteenth century, sibling orientation of British society led to *laissez-faire* economic policies that augmented the dependency needs of the majority. With no extended family to provide help in hardship, there has been in Britain a strong movement, even among the successful, for insurance and welfare schemes which have culminated in the so-called welfare state. In this movement, also, the old struggle between sibling and parental power is reflected, for co-operative welfare schemes represent the banding together of siblings in mutual assistance. But the scheme necessarily places power into the hands of its administrators; and places the beneficiaries in a dependent relationship. Thus the welfare state has been worked for with passion and voted for by the majority, and is cordially disliked by nearly all; for the father figure must not become authoritarian.

The perpetual paradox is that, though the English cultural pattern is a foremost example of successful and harmonious change, the English are tremendous respecters of tradition.

TWENTIETH-CENTURY STRESSES

Two disastrous wars within 30 years have affected successive generations at the same stage. Those who were exposed to the first war as young children were in the anxious position of being parents of young children in the second. Those who were parents during the first war suffered a loss of sense of direction. More thoughtful parents, unable to predict what adult life would be like for their children, realized that they could not prepare a child with confidence. The less thoughtful were bewildered and clung to whatever tradition remained with them, or perhaps embraced some new system or

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theory. The inter-war period was filled with child rearing cults each advocating the 'correct' way.

It now appears that balance had been restored by 1939 when the second war broke out, and the stresses of 1939-45 fell most where the culture is strongest, i.e. upon interpersonal relationships in the home and upon the emotional maturation and personal responsibility of the individual. Prolonged absence of the father, evacuation of the children and destruction of homes disturbed family balance and, with it, the relationship formation of the child. Distorted attitudes and identifications of children left a trail of social disturbance and, among some of the children who were then at a vulnerable age, lasting disturbances of character formation.

Once again, the culture has adapted and by 1960 the crest of the wave of family disturbance seems to have passed, though housing conditions are still abominable for far too many London families and particularly for many young married couples with babies.

The changing age balance of the population is a new source of strain. Greater longevity due to better nutrition, rising standard of living and medical advances, in combination with generally smaller families has increased the proportion of old people in the population. In a society composed of 'nuclear' families, the proportion of dependent old people per family unit may easily become insupportably high. Moreover, such a society will have little tradition of mutual dependence between the generations. The old person who has been independent of his own parents for half a century may strongly object to becoming dependent on his own children. It may be difficult for the latter to take under their protection a parent with whom they have enjoyed mutual respect and equality for 30 years, but with whom they have not lived for many years.

CLASS STRUCTURE

It is only relevant to our purposes to consider the class structure of British society inasmuch as it affects the behaviour of children. Though the British are certainly class conscious it is not difficult for a family to move from one social class into another during the course of a single generation. It is possible to descry five main types of family relationships related to social class but, of course, in addition to these five streams there are many subtle variations.

1. The more highly educated classes, including the professional people and, to some extent the wealthier have the highest standard of culture, but professional people nowadays frequently find that their income is inadequate to support the standard of living in which they have been nurtured. Though steeped in the culture, they are not slaves to tradition for they have acquired the highest degree of sibling self-determination that exists in the population and in addition are the most susceptible to outside influences through personal contact and education. They have flexible roles in their family life, e.g.

the father will share household duties and the care of the baby without feeling that he is doing 'women's work'. The mother will wish her husband to share even the tiny baby with her and, in return, will share responsibility for the later training and 'disciplining' of the child and for family decisions in general. Both parents will foster the independence of the child.

2. Artisans or skilled craftsmen, 'self-made' businessmen and small tradesmen will have something of the independent attitude of the professional classes, but will be narrower and less flexible. They will be more apt to adopt tradition uncritically, though cut off by modern industrial conditions from traditional family life. Their pride of craft will engender confidence and independence which, combined with their awareness of the fuller life of the more educated classes, will put them in the forefront of the fight for better conditions, a circumstance that increases the sibling weight in the social balance. In these classes of society there is often the paradox that the parents' ambition for their children puts intense pressure on the latter to learn, and may create a state of parental dominance that may often defeat the object. Such parental pressure generally results in a stricter and more rigid family life which, contrasting with the sibling orientation of the culture, may lead to anomalies and tensions in the second generation.

3. Among factory, office and shop employees, generally, clerks in the civil and local government services, but excluding those with higher education or professional or craft qualifications, family life will be very different. They will probably carry their ignorance of any type of interpersonal relationship other than that of superior-inferior into their home life. They are likely to have rigid ideas of roles. 'That is the wife's job', or 'My husband always does that', they will say, surprised that any question should have been raised. For example, care of the baby until he can walk is commonly 'the wife's job' and the husband takes no part. Housework is taboo for the husband, as part of a rigid division of roles that will extend to governing the behaviour which is considered 'proper' for the children at each age. The discipline of children is a major preoccupation in this class.

4. Unskilled working-class families rarely show much father dominance, but they will often have a greater degree of unsatisfied dependency needs. Their members are also less protected by trade skills, and are never in the position of boss. There may be a struggle between husband and wife for dominance, for both will have a need to exert authority, and both may well be anxious or insecure. It is a distinctive feature of stable working-class family life that a strong father or mother, and particularly the latter, can build up a family hierarchy that will constitute virtually an extended family group, and persist throughout the lifetime of the patriarch or matriarch, only to disperse abruptly after his or her death. Generally, working-class family structure is comparatively rigid and the regulation of interpersonal relationships therein, strict.

5. So-called problem families are composed of the dullest members of the unskilled labouring classes together with some others who are unstable, and they provide an unduly high proportion of child guidance problems. Among them, the pattern of family life is chaotic or formless, partly because of lack of conceptual ability and partly because of the weakness of the relationships formed by the parents themselves during childhood.

THE EMPLOYMENT OF MARRIED WOMEN

In recent years anxiety has been expressed about the effect on their families of the employment of young mothers, which is often cited as a cause of behaviour disorders and even delinquency. Though direct evidence is lacking most clinicians will *feel* that it will make difficulties in family relationships.

The amount of anxiety felt is possibly symptomatic of uncertainty in cultural change. In a rural society women join in gaining the family livelihood, and if their work separates them, temporarily, from their children, other women in the family will step in. The industrial revolution removed women's work from the home but not the nostalgia for the state of affairs in which women's work was in the home. The wife staying at home has become a middle-class symbol of family solidarity and of success. When economic needs overcome the stay-at-home sentiment, as in wartime, anxiety is raised.

The specific effects of maternal absence on children will be discussed in Chapter 3. An indirect result of women's employment may be to alter the husband-wife balance in the home and throw strains on family roles. The disturbing effects of women's work are seen mostly among the employed and working classes where family relationships are more rigid and the paternal and maternal roles distinctive. On the whole, the father protects and provides; controls and punishes. The mother nurtures, succours and trains. Among these families, the mother's absence at work may cause anxiety among toddler children and retard their development.

SOME DISTINCTIVE ASPECTS OF LONDON LIFE

No discussion of London life should omit mention of minority groups. In one sense any family moving in from the provinces will form part of a minority until full acculturation has been achieved; but there are some London immigrants who show more distinctive group characteristics: notably Welsh, Scottish, Irish, Jewish, Græco-Cypriot, Italian, Indian, Pakistani and West Indian.

In the last 100 years, London has developed centrifugally, mainly by the urge of young married couples to establish their homes on the 'edge of the country'. This mass migration has resulted in a vast, sprawling, amorphous, suburban agglomeration of houses, with considerable self-segregation by social class. Suburban dwellers commonly move to the seaside or country on retirement, but the next generation has already settled by that time, without

any strong trend to remain in the same suburb. The bulk of employment is to be found in central London, social contacts are widespread and marriage does not go by locality. Suburban life therefore lacks family continuity and is poor in community spirit. Slum clearance plans, wartime destruction of houses and post-war population dispersal have resulted in the organized transplantation of huge populations. A sociologically naïve policy has resulted in much social segregation by class without authorities being aware of what social problems are being incubated for the future.

The vacuum left by centrifugal migration has been filled by the immigrant groups, some of which have tended to form minority quarters. In general this has not been true of the Welsh and Scottish immigrants, whose acculturation problems are not distinguishable from those of comparable families from the English provinces. The Irish immigrants into London have not formed Irish quarters on the same scale as those in Glasgow, Liverpool and Swansea; but as a group they have suffered from serious acculturation difficulties, and often find the transition from Irish agricultural life to a London slum hard. Their family breakdown rate has been high and it is possible that their cultural and religious background has made them too rigid and too dependent on external forms to adapt satisfactorily, as a group. The failures among them tend to lose their distinctive Irish character without becoming closely acculturated to English life.

The Jewish minority consists first, of families domiciled for two or more generations in England which have, in general, acculturated very successfully, and their family psychiatric problems are not different from those of the Gentile majority.

Secondly, successive waves of immigration from Eastern Europe from about 1880 until 1914 brought people with memories of ghetto and pogrom, and they tended to form more closely knit Jewish communities, the progression of which, as wealth increased, from Stepney to Stoke Newington, to Golders Green and Hampstead has been the subject of envy among some less successful Gentiles. Wartime destruction has tended to disperse these previously closely grouped families and, perhaps, hastened their acculturation. On the whole their clannishness, their strong family mutual interdependence and their patriarchal, though not hierarchical family life has remained. Equally, their insecurity has remained, as shown by that overprotection of the young children and overdriving of the older ones, which has come to be considered almost typical of Jewish family life. Different patterns of behaviour among second generation families in Israel, and also the appearance of such supposedly 'typically Jewish' behaviour among families of British wartime evacuees suggest that this is immigrant minority behaviour rather than racial. The small volume of emigration from Britain to the newly formed state of Israel suggests that this group's acculturation has not on the whole been unsatisfactory.

Thirdly, Jewish political refugees since 1930 have had problems of acculturation that are too recent, and too pressing to admit of assessment yet.

The Italians in Soho and the Cypriots in several districts have retained more of their culture and remain strongly knit and essentially foreign until intermarriage with the English. Indians and Pakistanis have shown greater ease in adaptation and more quickly merge into the English pattern of life. West Indians have arrived in significant numbers too recently for a clear pattern yet to have emerged.

In conclusion, it may be remarked that, everywhere, human beings bring into the families which they are establishing, the ideals and hopes of their own childhood; and also their unsolved problems of personal relationships. Chapter 3 will be devoted to discussion of the effect of specific happenings upon individual attitudes. Here we have considered the numerous currents in the social history of these islands that have caused paradoxes and changes.

The characteristic dilemma of English family life is that the young need to control their own lives from an early age and parents are anxious that children gain this control, but without the help of a rigid external form. If children are too early thrown upon their own resources, paradoxical counter-tendencies may arise, the children may feel the need to be controlled and the parents to supply the control. How control can be provided vicariously, by institutional means, without disturbing the more congenial freedom of relationship between parents and children, is another British invention—the particular use made of the boarding school that is unique to the English culture. Though boarding schools affect less than 5 per cent. of the child population this includes a high proportion of future leaders. It is unwise to make the common assumption that the English boarding school is a sign of weakness of family life. It represents, rather, one of the social instruments of rapid cultural change for those classes most affected by the change.

Chapter 3

Growing Up in a Family

HAVING considered some broad family phenomena our next task is to examine the more specific influences within the normal British family structure of father, mother and young children. Although the remarks that follow apply most specifically to the English family, they are broadly true of British family life generally.

Family atmosphere may not be easily definable, but it is a most important influence on the developing child. Family atmosphere is a complex of aspirations and values, the resultant of the parents' adjustment to each other and of the children's identification with their parents. Much can be learned about family atmosphere from the parents' motivation for marriage and how this motivation relates to the accepted normal of the community. Unusual motivation, however healthy, will almost inevitably cause stresses; for example, a runaway love match in a community in which marriages are arranged by the family; or a 'dynastic' marriage deliberately made for purposes of family line or property in a community in which choice of mate is free. Where marriage is by free choice, which is generally true of Britain, unusual motivation for marriage implies abnormality of personal relationship formation. It would imply the existence of unresolved emotional complexes for an individual to abrogate the normal right of choice in order to secure a family or territorial ambition. However, British society can take care even of this, for in the small minority of British families whose highest value is property and social position, family atmosphere will implant an appropriate sense of values in the children. This is an important aspect of the family life of privileged classes everywhere—a 'Royal Family' can survive only by moulding its children's attitudes to its style of life.

In any special group children's attitudes are moulded unconsciously by prejudice implantation. To take an example, and this is true of any distinctive group—a certain family wishing to ensure the children's loyalty to the family faith, could not do better than to relate the children's behaviour constantly to their most highly valued principles. Praise meted out to the children in terms like: 'That's a good little —' and blame: 'No good — would ever do that', will forge a great bond of loyalty provided that the children have a positive identification with their parents. This process is not without risk: if the children's identifications have a negative aspect they may rebel and em-

brace an antithetical attitude; and if very strongly positive there may be unfortunate consequences from narrow mindedness and warped judgement.

The ordinary, culturally secure, British family will have no axe to grind, nor position to maintain. Where the culture is taken for granted, children are not subjected to special pressures, in contrast to the situation in a minority group, especially a proselytizing religious group, where pressure to preserve the minority position will be a powerful constant influence.

In the case of the culturally identified family which is free from particular pressures, unquestioning acceptance of cultural values will itself be an effective and certainly insidious agent for the formation of prejudice. It is often said that the British are 'very conventional', and never seriously question their cultural values. Parents who are secure in their cultural heritage will be motivated neither to question their values nor to establish rigid patterns of behaviour in order to protect them. The quality of spontaneity in their relations with their children will be the key issue. Their rich cultural heritage of history, mythology and folk lore will be used in mutual enjoyment with their children and neither as a propaganda instrument nor as a code of behaviour.

MOTIVATION FOR MARRIAGE

Normal British family atmosphere derives from the parental motivation for marriage and from what the parents are looking for in each other and in marriage itself. Sexually mature young men and women, ideally, are able to find in their partners the embodiment of their ideals in interpersonal relationships. Each finds a complement in the other. The love that is proverbially blind to faults is tolerant in its expectations. The difficulties of the offspring of such ideal marriages will be constitutional, incidental or accidental rather than emotional. Our concern, in child psychiatry, will be mainly with marriages in which the motivation is immature, or abnormal, of which four main kinds can be described.

1. Marriage in order to get away from an unsatisfactory home; in one sense every mature adult will find the parental home unsatisfactory for instinctual fulfilment, but in the sense intended here, the home has failed to satisfy normal childhood needs or is disturbed by unresolved tensions. If marriage results from a search for the fulfilment of unsatisfied childhood needs, the prospect of happiness in marriage is poor.

2. Marriage in order to gain a substitute parent: the man looks not so much for a wife as for another mother; and the woman looks for a substitute father. This situation will usually arise out of emotional deficiencies of childhood. Provided that the other partner reciprocates, the arrangement may work smoothly, but there is little chance of genuine maturation occurring. If children arrive, and these marriages are often not fruitful, it is common for jealousy to arise between the immature parent and the child.

3. Marriage because of social pressure: this happens most commonly to women brought up to accept a dependent female role. Particularly when some childhood insecurity remains, some girls by the time they reach 20 years of age are anxious lest they be left 'on the shelf'. The marriage of younger sisters may increase their urge to grasp any opportunity, however unsuitable. Among men there are similar reasons: 'it is time you found a nice girl and settled down', they are told; or, 'a man in your position needs a wife'.

4. Marriage because of more definitely neurotic pressures: this may have most unfortunate results. For example, a mother-fixated man may have an urge to prove his masculinity by marrying early; but the danger is that unresolved sexual guilt may make him impotent. He may fail to sustain the marriage, perhaps by being totally without consideration, by cruelty, or desertion; or, paradoxically, by infidelity, trying to prove his sexual potency. Mother-fixation may cause a man to marry a woman whom he imagines to resemble his mother; or the reverse—to differ from her. In either case the marriage will have shaky foundations, being dominated by the relationship between the man and his mother. Father-fixation, similarly, may cause a man to choose like his father chose—or unlike.

Young women are subjected to far greater pressure to marry than are young men, who can determine for themselves whether to marry or not. A father-fixated woman may marry in order to please her father or accept his choice of mate, without love for the man, with whom she may be sexually frigid. Occasionally sexual immaturity arouses sexual guilt so strongly in a woman that it is not assuaged by the religious sanction of holy matrimony. Such women are apt to be excessively possessive and seek to deny to their husbands a share in the child, and to banish all other masculine influence also.

Extremes of guilt or anxiety feelings may drive some men or women into a marriage of atonement, in which they seek by service to an invalid or deformed partner or other sacrifice, to get relief from guilt.

Many people marry from very mixed motives, among them being echoes of old and only partially resolved childhood conflicts. They may do well enough until they encounter stresses and then suffer a partial breakdown of adjustment. For example, a young wife may become intensely anxious early in her first pregnancy, and reject her unborn baby, or show an exaggerated fear of childbirth. She may experience much malaise and suffer from persistent and intractable vomiting. A likely cause of such a breakdown is an unresolved Electra situation, for a father-fixated girl may have adjusted fairly well, sexually, partly because she was following her father's wishes. Pregnancy may suddenly bring the full force of her conflicting relationships home to her and greatly increase her feeling of inadequacy. Her pregnancy will trap her, for once the process has started she cannot escape. She may be able to tolerate neither the responsibility of parenthood nor the dislocation of life that it entails.

SPECIAL STRAINS ON MARRIAGE

Wartime brought many special strains on marriage, of which the most obvious was the case of the couple who married precipitately, were immediately separated and, except for brief interludes of leave, were not reunited until the end of the war, when there might be two children of, perhaps 5 and 3 years of age. Meanwhile the wife had managed in uncomfortable and insecure accommodation—and had been both mother and father to the children. The returning father would be a stranger to his family, who had developed a style of life without him. He had to pick up the marriage relationship where little existed, and with young children already in the home. In this way, both partners would be robbed of the most valuable experiences of early married life.

The war nipped many young marriages in the bud, but the effects of wartime separation upon longer established marriages were sometimes equally disastrous. The father's absence and the mother's bearing of responsibility caused them to grow apart. One or both might be unable to readjust to the other in altered circumstances when reunited; or the returning father might be rejected by the children or, vice versa.

The exclusive masculine environment of the fighting service caused many men to split off their heterosexual behaviour from its normal setting of a lasting love relationship. Sexual intercourse became for them something that the man 'had', on his own as it were, wherever and whenever he could, as a normal course of social behaviour. So much the worse for his marriage when he returned home.

A common cause of wartime marriage failure was not sexual but educational. Husband and wife could not maintain communication when separated for 3 years or more. An officer who censored the letters of troops overseas would often read as follows: 'Dear Kitty,' the letter would begin in an ill-formed script with crossings out and spelling mistakes, 'I hope this finds you and the kids as well it leaves me. Please thank Mum for her letter and tell her I will write next week if I can find time. What a laugh you all must have had when Alf turned up like that unexpected.' Remarks about the weather would follow and an uninformative statement about the place he was in (because of censorship regulations); and finally, 'I reckon that is all for now Kitty. Please give Billy and Susie a kiss from their loving Daddy and a big hug for yourself. From your loving husband George.'

George might expect a reply in 3 months. No wonder unestablished marriages collapsed! Often letters would contain anxiety-provoking remarks like 'some of our chaps have got malaria, but no one's died yet'; or accounts of drinking parties with the boys.

PARENTAL ATTITUDES TO THEIR CHILDREN

During Pregnancy. Parental attitudes to pregnancy, as we have seen, will be derived partly from the culture and partly from the interpersonal relationships of the couple, factors which will combine to shape the expectations which parents will have of their children.

Pregnancy, obviously, will test the marriage relationship, but normally any fear and pain therein will easily be contained within the great sense of fulfilment of the sex instinct that the pregnant wife will have. Sometimes the father will be more frightened or distressed than the mother, possibly because his instinctual fulfilment is less direct.

During Childbirth. The normal mother's memory of her sufferings is remarkably short-lived, almost as if she had been partially anaesthetic as well as amnesic. Normal parents are too preoccupied with the baby's present and future to be interested in the immediate past. Their exaltation does not admit regrets—at least for a few days.

On the other hand, antenatal rejection of maternity by an emotionally immature mother may lead to fear, failure to relax, prolongation of labour and increased sensitivity to pain, which combination may even prove fatal. There is always the possibility that such an attitude is basically suicidal; the mother may not recover after childbirth, for she has neither strength nor motive to continue living. This, of course, is rare and most pathological; more usually the rejecting mother will either ignore the baby as far as possible, or else smother it with overcompensatory care.

The neonatal period may be one of intense anxiety and unhappiness to a mother with inferiority feelings, who may have a haunting fear that *her* baby is bound to be deformed. She will not be reassured by her own fleeting glance, nor by the doctor's or midwife's casual inspection of the baby. The delay before feeding is established may be insupportable for her. If, as is commonly the case, the doctors and nurses do not appreciate the mother's real needs, the lying-in period may gravely disturb the mother's emotional balance. It is normal for the mother's mood of satisfaction to pass away soon after the birth. Many normal mothers during the puerperium will shed tears of conviction that they will not succeed in rearing their baby. When the mother's inferiority feeling is strong her depression may reach dangerous proportions—even those of melancholia, though this last has other antecedents also.

The father's role is important though indirect, for if the partnership between husband and wife is less than complete, everyone will suffer. Attitudes such as that the husband has 'put his wife in the family way', because he insists on 'getting his pleasure', or he is 'selfish and inconsiderate' (i.e. will not practise birth control) poison the atmosphere of a marriage and distort the values of both partners. It is most unfortunate for the wife to have to go

through pregnancy and labour alone, without a sense of unity with her husband.

The unsupported wife may feel martyred; whereas the loving and loved wife accepts children as the creation of mutual love, the 'martyred' wife may feel that she bears children by her husband's selfishness out of her suffering and sacrifice. She may compensate herself with the children, tending them with an exclusive and jealous love that binds them to her and prevents their growing up. A classical example of the unsupported wife was that of Medea who killed her children rather than that Jason should have them. A modern example is provided by some wives who pursue a matrimonial quarrel far enough to destroy the happiness and future prospects of the children, by causing the collapse of the family.

During Early Infancy. Few British parents approach their task with sophistication and, as we have discussed above, they have to a large extent lost touch with traditional ways of baby care. As Dr. Margaret Mead has expressed it—our mothers have to read a baby care manual instead of listening to grandma. The majority, perhaps, will do no more than read Ministry of Health posters at Maternity and Child Welfare Clinics and perhaps listen to the public health nurse, if they think she has anything worth while to say; and read the weekly women's magazines.

Fashions come and go rapidly in parents' attitudes to tiny babies and, generally, in their expectations of their children at all ages. Unfortunately medical knowledge of bacteriology has far outstripped medical sophistication about human relations. The encouragement of first confinements in hospital, the provision of nurseries for new-born babies away from their mothers, and the flight from breast feeding to the more 'scientific' and more easily regulated bottle feeding have gone far to weaken the play of instinctual forces at the time of childbirth.

In the U.S.A. where 'scientific' trends have been even more marked than in Britain, fashion has reintroduced so-called 'natural' childbirth, but with organized antenatal relaxation classes, self-administered analgesics, lower segment forceps, planned episiotomy and 'rooming-in'—having the baby by day in the mother's cubicle. The reader may well doubt whether the latest fashion is much less divorced from instinct than its predecessor.

In Britain the majority of confinements take place at home, and in the hospitals staffing difficulties and unsuitable buildings (rather than intention) have commonly left new-born babies with their mothers, so that the main struggle between 'science' and 'instinct' has taken place at a later period of babyhood. When, late in the nineteenth century young mothers had largely lost touch with old ways of baby care, 'science' took the place of tradition. The new methods were ostensibly based on the conditioned reflex and on knowledge of bacteriology and biochemistry, but seemed to have derived as much from mistrust of instinct and spontaneity. The *Mothercraft* systems

based on regularity and careful measurement was, perhaps, the apotheosis of training for a machine age.

Even in days of universal education and powerful propaganda, such systems will affect only some of the more highly educated parents. The resurgence of spontaneity, however unspontaneous some of its forms have been in the U.S.A., has been a genuine return towards more instinctual modes of behaviour, and has quickly made an impression in Britain too. Self-demand feeding—its name changing significantly to self-regulation—was a return towards older forms of baby culture that had not been practised within living memory. Self-regulation is not the same as feeding the baby haphazardly merely to stop him from screaming; but involves at least a tacit recognition that the baby has a part to play in his own development. To concede this principle during infancy may facilitate the child's later progress towards self determination.

Naturally, many parents will apply self-regulation, or anything else, unwisely. An old cartoon depicted a mother dragging her small son along a seaside promenade. The boy is screaming loudly, while his mother is shaking him vigorously and exclaiming 'I've brought you here to enjoy yourself and enjoy yourself you shall'. Obviously self-regulation will work more easily if applied with understanding, and in general it may be said that British child-rearing practices tend to err on the side of making children take too much responsibility too early for their own behaviour.

Natural spontaneity is a more important influence than the actual form of the life lived by the baby. The mother who abides strictly by the clock in feeding is not necessarily more unspontaneous than she who feeds the child at the very first whimper. There have been strange excesses in teaching; on the one hand mothers have been told never to nurse a baby except on a cushion; on the other hand, they are told that skin contact is essential, that the baby should lie naked against the exposed breast, whatever the climate.

It will be useful to consider what are the appropriate parental roles relative to the main developmental features of each succeeding phase of childhood.

For the first 3 months the question is the baby's survival in radically altered circumstances, which involve the baby in orientation in time and in change from the constancy of the uterine environment to the basic feeding and sleeping rhythms of infant life. Parental adaptability and spontaneity will facilitate adaptation for the baby. Man has to be adaptive all his life and it is important that change should come easily to him, that it should be continuous and smooth. To impose a rigid pattern of behaviour on a baby may make it very difficult for him to adopt another, possibly also rigid pattern, when change has to occur.

An important aspect of parental attitude is the respect paid to the baby's right to receive proper care. Although the baby could scarcely ask to be born, yet many parents will demand gratitude from their quite young children and

be hurt when gratitude is not forthcoming. Parents would be better advised to study how to make their baby's life sweet and satisfying; and then, when he has developed the intellectual capacity to perceive his good fortune, to appreciate his parents' extra warmth and the high quality of their care, he may well be grateful. But until many years have elapsed and the child has reached this level of perceptiveness, gratitude is irrelevant. The mother who tends her child spontaneously will never think of gratitude; but the mother who tends her child conscientiously, but only as a duty, may feel that she has exceeded the minimal level of care and look for thanks which cannot be forthcoming.

Learning and training are important issues among British families. A common parental remark is: 'he must learn', and it would repay parents to consider the conditions that must be fulfilled before a child can learn.

Mothercraft logically exploited the conditioned reflex, by regularity of stimulus and reward in constant environmental conditions. It was hoped that regularity of behaviour would lead to a happy, contented and 'good' child. The method has disappeared from use, possibly because it is impossible to create a system of constant stimulus and reward. For example, many mothers like to establish a micturition reflex in their tiny infant. In about half the cases, the reflex will last during suckling, while the child is having a fluid intake of constant quantity, composition and timing. When feeding becomes mixed, and times of feeding, exercise and temperature vary, the reflex usually breaks down. The child was conditioned to empty his bladder when sat on a pot; which is different from real toilet training—withholding micturition until circumstances permit of emptying.

The example illustrates the limitations of conditioning of babies. The conditioned reflex establishes a stereotyped response to a stereotyped stimulus, whereas the child must adapt continuously to a constantly changing environment.

It appears that a young child will learn best when he has a smoothly adapting relationship with the environment. This is obvious in respect of time and space, but it is probably more importantly true in respect of the parental relationship. Many parents set store on the child's obedience, without realizing what any experienced soldier knows, that obedience can only develop fully in a relationship of trust and security. Many British fathers returned from war service to find their children 'out of hand', resentful, hostile and 'disobedient'. Their attempts to 'discipline' the children were hampered by their lack of relationship with them.

Some parents behave as if bringing up children were a tug-o'-war, with the victory to him who tugs the hardest. They work to create an ascendancy over the child from the start, and regard the child's difficulties in adapting as subversion. Possibly this parental attitude is a projection of hostility on to the child. Parental hostility is usually no more than a certain ambivalence, but

a more neurotic hostility may appear out of displacement from the leading position in the affections of the spouse. Other, more subtle forms of hostility may arise from the frustrations, fears and disappointments of family life.

The realization of hostility to a baby may shock a parent who considers himself normally affectionate and responsible. Thus the parent awakened in the night by a screaming infant may be so unreasonably exasperated as to feel almost ungovernable anger, and may feel very ashamed afterwards. This, though disturbing, is a salutary experience for a well-balanced man or woman.

Many parents base their conduct towards their children on their own childhood recollections which, obviously, may have become seriously distorted. One common source of difficulty is that the parent exaggerates the respect in which he held his own parents and represses the recollection of his own struggles for independence; another difficulty is that the parent may apply his own recollections of 6 years of age to his 2-year-old children.

The Toddler Period. The cultural emphasis on children growing up to be independent and self-reliant, that exists in Britain, is hardly reflected in the consciousness of most parents. On the contrary, the absence of codes of behaviour and of dependence upon minutiae of tradition have tended to increase parents' need to control children and to exact obedience from them. The British have a reputation for being fussy and strict with their young children, especially in such matters as table manners and toilet training.

British families are nervous about 'control'—whether self-control, or obedience to parents or especially in connection with sibling rivalry. The two little boys fighting in bed are told: 'Little birds in the nest must not fall out', but underneath the little nursery joke there may be maternal anxiety, for the culture depends for its strength partly on the successful deployment of sibling rivalry into sibling co-operation. Sibling aggressiveness though encouraged, is strictly regulated as in team games, which also foster co-operation. The mother is often uncertain how to handle her child so that his capacity for self-control will keep pace with his developing aggressivity; perhaps she does not trust her child sufficiently.

Ignorance of the child's capacity is a major parental difficulty. For example, toddler children are commonly required by their parents to concede fair shares and take their turn. In order to do this successfully the child must have not only the intellectual capacity to perceive the advantages of equity but also must be able to control instinctual drives. However, toddlers of 2 or 3 years old have difficulties in identifying their own bodies and are rarely able to perceive the rights of others; and only the most stable, secure and advanced children of that age are self-controlled.

The Pre-School Child. Social adaptation becomes important during the immediately pre-school period, and its nature will vary widely between social classes and localities. In urban working-class areas children are early

introduced to children's society at home and in the street. The latter experience of social adaptation produces failure as well as success. In sharp contrast, the middle-class suburban child's parents often complain 'There aren't any other children within reach', in other words, no other children with whom they wish their child to associate.

The School Child. School entry is an inescapable test of the child's social adaptability and emotional maturation. For successful adaptation a child must be sufficiently detached (or detachable) from his parents to be able to form some of his relationships outside the family circle.

The period between 5 and 11 years of age is characterized by a comparative stasis in the more direct manifestations of sexual evolution. Early on, children show rapid intellectual development; and later in the period the extension of social relationships becomes more important than the deepening of intimate interpersonal ties. At this phase disturbances caused by sibling jealousy and competition will radiate far outside the family circle, and not only will there be social pressure to control sibling rivalry, but also anxiety to protect the rights of the individual and, particularly, property. These matters loom largely in the so-called character training of junior schoolchildren.

When the child has transferred some of the affect previously tied exclusively to his family to members of the school group, he will gradually become ready to form more abstract types of relationship. Transference of some of the affect from the parent to the teacher marks a subtle change, from relating to the individual as such, to the position. This further refines the child's system: at first he was good in order to please the parent; then in order to be like the parent; and later, because he values what the parent values. When his affect system includes the position of authority in addition to the parent, his value system becomes extended similarly.

The values of the contemporary group become very important for the school child. Informally the child may develop a sense of solidarity with an 'in-group' of children, and more formally, with the class. The 'Spirit of St. Blank's' is traditionally used as a spur by schoolteachers, and more recently the 'Old School Tie', though thought by some people to symbolize an over-exclusive and over-privileged class, in itself will symbolize an extension of the child's loyalty system to his group. Its danger is that the extension of loyalties may stop within the visible social group, instead of enlarging to embrace the district, the country and, in the case of comparatively few people, humanity itself.

As social loyalty extends, value systems will become more abstract. The child comes to appreciate the inherent worth of what the parent values. Likewise, the concept of 'public school morality' goes together with the 'old school tie'. The boy values what his group values. The older citizen values what the nation values, and the truly mature citizen has at heart the highest values of humanity.

Spontaneity and warmth of the parents will set the style of family relationships, which strongly influences the character pattern of the children. Warmth and spontaneity engender a loving return, the children's affection will be strong, and jealousy and hatred will find expression too but, what is of vital importance, will also find control. It is most important for a child to be able with confidence to control his strong conscious feelings.

THE BROKEN HOME

The broken home, as a result of which the normal living together of both parents with their young children has been interrupted, is a recurrent theme in clinical child guidance. Perhaps the most serious effects will be found when the young child is given an impersonal upbringing, and denied the normal interplay of emotions.

In Chapter 7 there will be fuller discussion of the notion that when no satisfactory substitutes are found for the child with no parents, his early relationships will be formed at a low tension of affect. This may lead to weakness of personal identification—of ego formation. The child may not find out what is 'I' and 'not I' until quite late, and may be permanently weak in definition of self and ego strength.

A similar low tension will accompany the modification of instinctual drives. With careful supervision the toddler child may train easily but the essential character-forming experience of training will be deficient. Occasionally a paradox is met in clinical practice that a mother may fail to wean or train her child in toilet habits and a nurse completes the job in a few days, with the child perfectly docile. The mother will be considered incompetent; and the nurse 'very good with babies'. But there may be more in this situation than meets the first glance. Training may have been difficult because of stress in the mother/child relationship. Commonly the mother's failure fully to satisfy the baby's needs results in a negative response to her attempts to modify the baby's instinctual drives.

Friction is an important ingredient of emotional growth and the overcoming of difficulties by mutual action gains the child experience in controlling his own turbulent feelings and gives him confidence in his mother. In return, the mother's pleasure in the mutual achievement helps to build his ego strength, which is the best foundation for superego development.

The baby does not resist weaning introduced by a nurse because he has little affect invested in the gaining of satisfaction in *that* particular way from the nurse, who herself gets little pleasure from the achievement. Therefore the child will gain little accession of ego strength or character development, from the experience, and will be no readier for the next step.

The character difficulties associated with impersonal upbringing derive from an ego weakness that leads to poor superego formation. We have suggested that interpersonal friction is an essential ingredient of character

growth, and perhaps the worst risk that young parents can encounter is to have a docile, sleepy, inactive baby. It is a danger signal to the doctor when a mother says: 'He is so good, doctor, I sometimes peep at him to see that he's still there; the neighbours all say that they wouldn't know I had a baby.' Such remarks are commonly found in the histories of autistic children. To experience and to control strong feelings are crucial to learning and to character development in the young child.

The lack of this essential learning and developing experience, from which impersonally brought up children commonly suffer, will have serious effects during the so-called Oedipus phase, when the child is sorting out its relationships. Strong child-parent identification, together with adequate primitive instinctual satisfactions and a smooth pattern of instinctual modification, will result in strong ego and superego formation, and thus stable character formation.

On the other hand, weak affective relationships will result in weak patterns of identification and of introjection of the child's concept of the loved adult. The developing internal moral agency will remain weak, and leave the child dependent upon an external framework of control rather than upon inner character. Such people seem to be 'superficial' or of 'weak character'; they derive their attitudes from their surroundings rather than from their own identifications. Moreover, their deficient own inner experience will give them little empathy or intuitive understanding of other people.

Those who are impersonally brought up lack experience of jealousy in important emotional relationships. In normal family life the child learns from being gradually forced from his babyhood position of dependence on his mother and his self-centredness. Sibling rivalry, the competition among the young children for the mother's love, is a normal ingredient of family relationships and will give children the experience not only of feeling strong emotions—love and hatred—but also of their control. These are practical exercises in the management of ambivalence, of enormous value in preparing the child for more adult society.

THE INTERRUPTION OF CHILD-MOTHER RELATIONSHIPS

Another effect of a broken home on the young child may be the interruption of a maternal-child relationship which has already been formed; and the effect of interruption at various ages, like that of absence, will be illustrated with clinical examples later in the text.

Interruption of the relationship between child and mother can have characteristic results from about the age of 6 months, onwards. Spitz¹ and² and others have noted three successive phases through which the child will pass: (a) protest, (b) mourning and (c) apathetic depression. Children's behaviour will vary in each of these phases according to temperament and to strength

¹ See footnote, page 6.

² Spitz, R. A. (undated): Grief, a peril in infancy.

of relationship already formed. Thus, the hyperkinetic and out-turning child may show prolonged and vigorous protest but less mourning; and remote restlessness and abstracted activity during the phase of depression. The in-turning child may show little or no obvious protest, prolonged mourning and a withdrawn, unapproachable and unmoving depression.

When the relationship break coincides with an important developmental advance the disturbed child will fail to take the new step; perhaps reject the new experiences outright, and probably regress to an earlier stage of behaviour. The weaning child will refuse solid food and cling to the bottle. The toddler will stop walking, return to thumbsucking and other baby ways. The toilet-trained child will start wetting again. The child who has progressed some way into forming family relationships, who has given up his exclusive demands on his mother, when separated from his mother may reject the comfort offered by his father and by his siblings whom he ordinarily accepts, and cling inconsolably to any woman who reminds him of his mother.

IMPAIRMENT OF CHILD-MOTHER RELATIONSHIPS

Interruption is the most common cause of long-lasting impairment of the child-mother relationship, and during the suckling period can lead, in the child, on the one hand to an out-turning reaction—persistently active, restless, unsatisfied, greedy behaviour; and on the other hand, an in-turning reaction—a persistently inactive, subdued, somewhat withdrawn, lack of thriving. Behaviour patterns can vary widely and to some extent will be determined by constitutional factors (see also Chapter 1).

The baby that is born hyperkinetic, restless and unsleeping will be unadaptable and will early prove an irritant to his surroundings. He is apt neither to feed nor to sleep at the convenient time and may quickly undermine his mother's confidence. The clinical examples will show how a vicious circle can develop: that the child's hunger may impede his food taking, and by interfering with his sleep increase his already intense activity, which will increase his food needs. Parents' despair over the child's non-eating and their exasperation over broken nights will quite take the joy out of parenthood and seriously impair family relationships. The child, having been deprived of the real satisfactions of infancy, will be ill-equipped for instinct modification, experiences. His behaviour may remain at the infantile level of egocentricity, and the harmony of the home will be shattered.

The too-placid, drowsy and still baby faces no lesser hazards. He, too, may be hard to feed, but his food needs will be slight and his behaviour will disturb his mother less. The danger that he runs, as mentioned above, is of neglect, for it is difficult for the mother to stimulate an underactive child and if not stimulated he will not thrive; his feeding will be poor, growth retarded, and development landmarks reached late. As a toddler he will be unadventurous

and timid, and his life experience will remain restricted. With weak instinctual impulses inadequately satisfied, his ego will remain weakly developed, his superego likewise, and a timid, irresolute character may result; shrinking, expecting little of life and achieving little, too.

The outcome of a relationship impaired by interruption will depend upon the quality of substitute relations; but additional difficulties will arise when parent and child continue to live together when their relationship has been impaired.

To take first the case of a baby whose early relationship with his mother was warm and vital and afforded him reasonable satisfaction of his needs; but whose mother was immature emotionally, though not entirely cut off from her own instinct life. Let us suppose that the appeal of the tiny, helpless baby was sufficient to enable this mother, with her own mother's help, to cope well enough with her baby's infancy. But, as soon as the child started showing independence, this mother progressively failed to provide for his needs. She could not introduce him favourably to the new little experiences that are important in later infancy, thus failing to give him experience of successfully overcoming minor frustration. This provoked either a clamouring, restless reaction, or a withdrawal and failure to thrive. Whichever it was, it would undermine what little confidence the mother might have in her capacity to handle the situation, and would bring out into the open her underlying rejection of her baby.

Secondly, a poor maternal-child relationship may start a chain of reactions with serious significance for the remainder of the child's life. Infantile life is centred on the feeding cycle: hunger, restlessness, crying and (presumably) discomfort; feeding and (presumably) pleasure; satisfaction, relaxation, comfort and sleep; hunger, etc., etc. This cycle recurs some five times a day and it is always the mother who not only ends the discomfort, but who also provides, immediately, the pleasure of feeding and, consequently, the satisfaction of repletion. In the security of this cycle the child first perceives the mother as something apart from himself, then conceptualizes, however primitively, the maternal function.

It has been suggested above that some out-turning children will disagreeably seek to gain the satisfaction they lack; and some in-turning children will withdraw and fail to thrive. It is of more serious significance for the future if the unresolved tensions of the instinctual cycle dominate the concept of mother that these children form. Mother, instead of being the pain curer and comfort provider may literally become the pain prolonger and comfort denier. Moreover, since the experience is felt mainly internally by the baby, he may never be sufficiently free from internal tension to conceptualize his mother as something separable from himself. The serious implication of this possibility is that the child may conceptualize the frustrating agent as integral with himself.

The immediate practical consequence of lack of satisfaction is mistrust of change. The child who does not conceptualize his mother as the source of all satisfaction will possibly resist all change introduced by her, e.g. will show regression and, either, an out-turning and greedy, demanding reaction; or a withdrawing, passive pattern.

Another possibility is inhibition, which, with the general theory of aggression to which it relates, will be discussed in Chapter 8. Towards the end of the first year of life, a salient feature of development is the appearance of directed aggressivity.¹ The primitive, chaotic aggressivity of early infancy acquires organization; the child's developing capacity to perceive objects in space, to direct his movements and to manipulate instruments give his aggressivity a direction that, for the first time, will make it potentially dangerous. The necessary apparatus for its control will normally be supplied by the mother's training and discipline. If it should happen that a mother who has attempted to wean the child without adequately supporting him, should be the same person who must control his reaction, a painful situation may arise for the child. Some children so placed will repress their aggressive impulses and retreat from anger-provoking situations. They lose spontaneity and become rigid and inhibited, so that, at the worst, in situations requiring change or adaptation and, more especially, the output of aggression, they will freeze into helpless rigidity.

From the time of weaning, onwards, a *leit motif* in all environmental and social situations is the proper deployment and control of natural aggressivity. Temper tantrums and lack of control are very prevalent among toddlers before their self-control has become effective. Subject to the quality of the child-parent relationship, the child's deployment of aggressivity will determine his style of life—his acceptance of training and reception of inevitable frustrations.

The child who accepts frustration by the parent is open to the parent's training, can identify with parental standards, and introcept them. Where no relationship exists, the child will not accept what passes for good in the home. Where a formed relationship has been broken, the child's love and trust may be replaced by hatred and suspicion, by opposition and rejection of the parent and parental values. A possible result could be hostile antisocial character formation, actively motivated into immoral behaviour.

Poverty of parental relationship may cause the child to be retarded also and regressed in emotional development throughout childhood; or to form a neurotic over-identification with one parent, so that normal sexual differentiation will be distorted either by developmental failure or by identification with the opposite sex. Clinical examples of these and other outcomes will be found in the later text.

¹ The term *aggressivity* is preferred here to *aggressiveness*, because the latter has acquired a moral value that is misleading in the current context.

It will be emphasized repeatedly in clinical examples that not less crippling to a child's later development than the original cause of a difficulty, will be the cumulative effects of regression and the child's compensating behaviour.

Finally, a word should be added about the distinctive atmosphere of the minority family, which has been referred to in Chapter 2. Minority families tend to set an enormously high value on one particular aspect of life or set of values. The expatriate family tends to increase the value set on family relationships, as seen, for example, in the family life of most Jews in Western Europe. This often leads to assumption that family life is 'stronger' among Jews than Gentiles, but it would be more accurate to state only that certain aspects of family relationships are strong. It is characteristic of religious and political minorities to have certain special values in common, and the particular system which distinguishes a group will become a central theme and symbol of family life, with consequent effects on the character development of the children.

PART II

The Prelude to Life



Chapter 4

Gestation

FROM earliest human times, pregnancy has been surrounded by myth and magic and this is still true to some extent in the Western world. In ancient times divine qualities were attached to abnormalities of pregnancy. Supernatural beings were supposed to procreate by unusual processes: like the earlier Greek goddesses who had their babies mostly by fission, parthenogenesis, or by that most impressive magic, virgin conception. But just as divine interference was supposed to produce superhuman creatures, so might subhuman creatures and monsters be fathered by demoniac possession.

Many primitive fantasies and fears still exist in Great Britain about the later influence of pregnancy and incidents during pregnancy upon the child. Many people strongly believe that women should do, think and feel only certain things while pregnant, for the sake of the unborn child. Beliefs about the effects of emotional shocks are widespread; thus a baby's birthmark may be ascribed to the mother seeing a rat; or the child's talipes equinovarus to the mother seeing a deformed foot—often, for some magical reason, in the third month of pregnancy.

Though various somatic disasters can happen during pregnancy—infection, mechanical damage, biochemical and metabolic anomaly, neoplasm, or placental disease—there is no evidence that experiences and particularly the mother's emotional experiences, can affect the baby directly. The only route of communication between mother and baby is through the semi-permeable placental and foetal blood vessels. As far as is known, foetal special senses cannot function, and the foetus will react only to biochemical and pharmacological stimuli and, during the last weeks of pregnancy, to light touch stimuli applied to the mother's abdominal wall.

The psychological importance of pregnancy lies in the preparation it gives the mother for her maternal functions, and the foetus for independent life. The mother's experiences during pregnancy may affect her attitude to the baby in a direction that her level of emotional maturity will determine.

To the mature, well-balanced woman whose marriage is happy and secure, pregnancy will fulfil her strongest instinctual drives. The early months will bring her an unique happiness and sense of well-being that will be greatly enhanced if genuinely shared with her husband. Early in pregnancy her sexual activity will probably increase and be reflected in her total body conformity and physiology.

Pregnancy is a discipline and a training as well as a joy; for the future mother's situation will have changed permanently. Her body is no longer entirely at her own disposal but is caught in an irreversible biological process, and after giving birth she will have a baby to serve with her body. The mature woman will gladly pay this price for her instinctual fulfilment. In the latter half of pregnancy most women tend to withdraw somewhat from the environment. Some will be almost rapt in their contemplation of life within, and find all their contentment in their preparations. Where love is warm, fear scarcely enters into what may be the happiest period of the mother's life, though impatience and increasing physical difficulties may make the last few weeks irksome.

To such a mother labour will set the seal on the experience. Some women will refuse an anæsthetic because they wish to experience everything that comes to them. It has sometimes been believed that travail and suffering cause the intensity of mother love, but this belief has little to support it. Good relationships and the mother's maturity will give her an intense enjoyment of her pregnancy and an eager acceptance of the baby. Moreover she will feel that she is doing all this, not for herself, but for her loved husband.

Unhappily, pregnancy will come to many women as a devastating shock, and to others as a nuisance, an interference or an imposition. There are many social reasons for this: illegitimacy, marital discord, poverty or ill health; but our concern is with more subtle psychological causes and effects.

The usual cause of psychological rejection of pregnancy is the mother's emotional immaturity or emotional poverty. Old unresolved father fixation is a potent factor, but a commoner reason is general unpreparedness for the responsibilities of adult sexual life. Some women marry for social reasons rather than for the relationship, and try to cling to their childhood privileges. Marriage brings them an infantile level of erotic gratification, and pregnancy makes them feel cheated and caught in the toils of something they may bitterly resent. For them pregnancy will mean, not fulfilment of instinct, but curtailment of infantile type satisfactions.

The outcome will depend on the resolution of conflict between instinctual drives to maternity and existing infantile instinct satisfaction patterns. Conscious rejection of pregnancy among married women is commonly rationalized into something acceptable to the superego. Family planning is the great rationalization. She feels not ready 'yet' for maternity, or not enough money is coming in for education. Less abstract rationalization is found in acute fears of the confinement. On the other hand, strong over-compensation may make the pregnant woman totally obsessed with the process. Either way will lead to tension and relaxation difficulties in labour.

Unmarried women may consciously reject pregnancy for many social and moral reasons in addition to their psychologically unsupported position. But except in the case of rape, it should be remembered that the woman has been

motivated to become pregnant in spite of many powerful reasons against.

Some narcissistic women will have a very serious adverse reaction to pregnancy, based on father fixation. The narcissistic woman may accept love and sexual intercourse as homage to her person, and pregnancy as the fulfilment of her ego ideal. She is almost bound to be humiliated by the baby's invasion of her body, the bodily embarrassments of later pregnancy, and the indecencies of labour. A narcissistic woman will do the right things with a remarkable lack of spontaneity. She may romanticize maternity and become precious about it, and exclude her husband from any real part in the business. After the birth she will seek compensation in the baby for all the suffering that she has endured; and family relationships are bound to suffer.

THE BABY

It will be wise to consider the possible meaning to the baby, of life in the uterus. As a matter of speculation, at least it can be said that all subsequent experiences of the baby represent a change from the environment of the uterus, which is the point of departure in the baby's process of adaptation.

There is no evidence that a foetus has any functioning special senses or sensory and motor nervous system, other than co-ordinated action of the alimentary canal, and the reflex movements of arms and legs, known as 'quickening'.

It seems unlikely that a baby will retain percepts or memories of life in the uterus, but there may be routes of extrasensory perception of which we are ignorant. The idea that the foetus has a memory might be dismissed summarily, were it not for our general ignorance of the basis of the infant's understanding with its mother. There is also the curious circumstance that the myths of many cultures, preserving the collective memory, the fantasies and the nostalgia of the culture, refer to a Golden Age and a Fall.

In the Garden of Eden, the Greek Golden Age and in the Valhalla of the Norse Gods, life was perfect; set in a regular rhythm, nothing unforeseen occurred, all wants were met before they were even experienced, there was no work, no responsibility and no independence. This has a curious resemblance to the life of the foetus, cushioned, warmed and fed automatically, with everything provided at no effort.

From the prevalence of such myths it might almost be supposed that universal folk memories are attempting to penetrate the concealing mists of childhood, to see behind a life of effort, pain and struggle, a serene existence to which Mankind really belongs. Likewise, the common folk myth of the Great Disaster: the Fall, the opening of Pandora's box, or the Twilight of the Gods, and the rebuilding of a life of effort, trouble and responsibility, may conceivably be a folk abstraction of the universal experience of being born and of growing up through childhood.

Whatever may be the foetal capacity for memory, it will be agreed that uterine life differs remarkably little from life during early infancy even

though the total circumstances are radically altered, but it is separated from the latter by the contrasting episode of birth.

DISASTERS OF PREGNANCY

Description of the effects of disasters during pregnancy will be found in textbooks of pædiatrics and mental deficiency; but we need here briefly to consider their possible psychiatric significance, and to what extent they may impair development, and also the mother's and the child's pattern of reaction.

These disasters include developmental anomaly, endocrine and biochemical disorder, metabolic disorder, nutritional disorder, infection, hæmolytic disease of the foetus, and new growth and placental disease.

Developmental Anomalies. First, generalized germ plasm defect, if sufficiently severe, will result in congenital mental deficiency combined with some degree of somatic deficiency (see Chapter 6). Secondly, local organ defects may occur, e.g. neurological anomalies causing congenital pareses, tremors, incoordination, and so on; or failure of the thyroid gland leading to cretinism. A third class of temporary defect is more difficult to define and in Chapter 1 we have discussed four conditions necessary for development: constitution; matrix; nutrition; and 'activator'. Absence, however temporary, of any of these conditions may prevent or impair development and in the case of both local and temporary defects the whole course of subsequent development of the individual may be affected.

It now appears likely that mongolian deficiency, which is illustrated by a clinical example given below (Billy L. (1), p. 50), is due to an aberration of development. Although the condition has been recognized for a long time, its cause has remained obscure. Its uniformity has indicated a unitary cause operating at a standard time, but studies in heredity have produced only conflicting results. Pituitary lack, maternal reproductive immaturity or exhaustion, malnutrition, vitamin deficiency, uterine infection, foetal brain damage and so on, have been examined, but without convincing result. In recent years it has become usual to regard mongolism as a developmental defect of uterine origin, at the eighth week of gestation, the period being fixed by radiological evidence of the standard maldevelopment of the fifth middle phalanx.

Within the last year, publication of the discovery of an extra chromosome—making 47—present in cases of mongolism has indicated that the cause may be a primary disorder of oogenesis. Until this strong possibility becomes a certainty, however, and because mongolism is the only common type of mental deficiency that is usually recognizable at birth, this condition will be classified here with the disasters of pregnancy.¹

¹ Penrose, L. S., *et al.*: 'The chromosomes in a patient showing both mongolism and the Klinefelter syndrome' (1959) *Lancet*, 1, 709. Jacobs *et al.*: 'The somatic chromosomes in mongolism' (1959) *Lancet*, 1, 710.

There has lately been concern about damage by ionizing radiation from the accumulation of X-ray doses, and so on. Foetal tissue is very sensitive to ionizing radiation and, though the central nervous system is comparatively resistant, within the first two weeks of foetal life the brain will be sensitive to doses of the order of 100–200 roentgens, which can cause serious malformations of the brain. Unfortunately for prophylaxis, by the time the mother knows she is pregnant, the vulnerable period will have passed.

Endocrine, Biochemical and Metabolic Disorder. The psychiatric effects are largely non-specific, and will be those resulting from organ failure and the accompanying compensation pattern. Recent attention has been given to the rare appearance of phenylpyruvic acid in the urine of the new-born baby in association with mental deficiency, but this is not strictly a foetal metabolic disorder.

Nutritional Disorders. These have little specific psychiatric significance. Maternal starvation has surprisingly little effect upon the baby, other than slowing and limiting growth but, of course, the mother's attitude to her baby may be adversely affected.

Infection. Modern treatment of venereal disease has made foetal syphilis and especially juvenile general paralysis so rare as to be discountable in child guidance practice. This subject is well covered in works on neurology.

Epidemics of rubella¹ in 1940 in Australia, England and U.S.A. showed an important association between maternal rubella in the first 3 months of pregnancy and cataract, deaf mutism, cardiac defects, and a number of other congenital defects, including microcephaly and mental retardation. The seat of the lesion is determined by the degree of activity of development of the tissues at the time of infection. Mumps and other virus diseases may possibly be occasionally responsible for congenital defects. Pregnant women should avoid exposure to infection; and, if exposed, should be given convalescent serum, or better, gamma globulin produced from it.

Hæmolytic Diseases of the Fœtus. Hæmolytic diseases of the foetus and new-born baby are caused by agglutinins in the maternal blood that destroy the foetal erythrocytes, and brain damage will result.

Clinical manifestations include general œdema of the foetus; neonatal hæmolytic anæmia, icterus gravis neonatorum, and certain cases of habitual abortion.² The malady may follow the birth of more than one *Rhesus positive* child to a *Rhesus negative* mother and a *Rhesus positive* father. It appears that an escape of foetal *Rhesus positive* cells into the mother's circulation sometimes but not invariably stimulates the production of antibodies by the mother. Once the mother has become sensitized, subsequent *Rhesus positive* infants are likely to increase the production of maternal antibodies;

¹ See *Diseases of Children*, 4th edition, edited by Patterson and Moncrieff. Vol. II, Chapter XV; *Infectious Diseases* by H. Stanley Banks, pp. 848–9.

² Richard W. B. Ellis, *Disease in Infancy and Childhood*, 1951, pp. 96–8.

but if the *Rhesus positive* father is heterozygous there will be equal chances that subsequent babies will be normal.

One clinical variety is kernicterus—staining of the basal ganglia, etc, together with various neurological disturbances, notably opisthotonus, athetosis and subsequent mental defect. Usually more than the basal ganglia are involved and cases are frequently classified as 'cerebral palsy' (see Michael L. (5)). *New Growth*. Has no specific psychiatric implications.

Placental Disease. This will damage the foetus through insufficient nutrition and especially, inadequate oxidation, e.g. resulting in small size, permanent constitutional inferiority, neurological damage and/or prematurity.

Prematurity may cause a variety of problems arising out of the effects of the experience upon the mother, e.g. her debilitation, her doubts about being able to rear the child, or her unpreparedness due to curtailment of the time of preparation. There is no clear-cut psychiatric prematurity syndrome. Premature babies may make up their bodily and mental immaturity within a few months, provided they have no irremovable residual deformity, but prematurity is associated with very many developmental anomalies. A serious social problem has arisen, in that modern skills in resuscitation are keeping many more severely handicapped or seriously inferior babies alive, without a commensurate increase in the help given to the unfortunate parents.

MONGOLISM—AN ABERRATION OF DEVELOPMENT

Mongolism is sufficiently common to merit a brief description in a work on child psychiatry and the case of Billy illustrates most of the characteristics of this condition.

Billy L. 6.0 years (1)

Billy lived with his parents and sister Edna aged 4, in a council flat. Mr. L. was a milk salesman, and they were careful people, rather over-anxious about the children. They were appealing against Billy's ascertainment as ineducable and complained that the test had not been fair. 'He could have done everything he was asked, at home,' they said, 'but he was more interested in looking around than listening to the doctor.' 'There is nothing like it in the family.' Mr. L. was the eldest of five, and Mrs. L. the third of four siblings, all healthy and with normal children. 'We've thought of everybody and there's no reason why Billy should be like this.'

According to these campaigning parents, the pregnancy was uneventful. Billy was a wanted, first baby. Mrs. L. was 26; slight sickness around 6 weeks and some cramping pains towards the end. Birth was at term; labour lasted 18 hours; no instruments. Birth weight 5 lb. 7 oz.

Before Mrs. L. was allowed to see Billy on the second day, the doctor warned her that he would never be normal. She bitterly resented this, at first seeing nothing wrong, but later she realized he was not normal. She was so alarmed that she could not breast feed him and bottle feeding was very difficult also. He could not suck properly and choked whenever he took a mouthful. He gained weight very slowly.

All Billy's developmental landmarks were late; he did not fixate his eyes, and later

developed a squint. He responded to his mother at 8 months, and sat up unaided at 12 months. He did not crawl, but Mrs. L. got him on to his feet, holding on, at 2 years. He walked alone at 3. He weaned to solids easily, but did not feed himself until after 4. He was dry by day at 4 and occasionally by night at 6. He had much baby talk, but spoke recognizable words after 3 and had very little sentence formation at 6.

As a baby Billy was inert and unresponsive, though easy and cheerful. He became livelier when he walked and at 6 was a cheerful and lively soul, joining in everything to the best of his remarkably little understanding. He liked music, or, perhaps, rhythm. Edna had long since overtaken him.

The parents appeared to try to keep Edna back, or at least to conceal her attainments from Billy. He was spiteful and jealous of her; and she was having disturbed nights and was clinging to her mother, who was unsympathetic and critical of her.

Psychological testing was difficult because of Billy's limited comprehension of the test situation, fleeting attention, and motor clumsiness. Merrill Palmer Scale for Pre-School Children, Mental Age 2.8 years, with some refusals and doubtful results.

Billy was small, with decidedly pyknic build—short, rounded limbs, round head and short neck; brachycephalic skull. He had downward slanting, almond shaped eyes, bilateral epicanthic folds and convergent strabismus. Tongue large, thick and granular looking; palate narrow and highly arched. There were no lobules to his ears; badly decayed teeth; skin rough and hair scanty. Hands broad and spade shaped, with short in-curving little fingers and single palmar furrows. He had an extremely hypotonic musculature; his thumbs could passively be made to touch the forearm. Protuberant abdomen and a deep cleft between the first and the second toes; poor circulation and bad chilblains. He was much subject to bronchitic colds.

Billy had a broad grin and was socially responsive. He was interested in the toys. He played at an infantile level of clumsy manipulation. His speech was typical of mongols—minute vocabulary and lalling pronunciation. When asked a question he was silent momentarily and then a hoarse noise erupted from the region of his boots, with an almost explosive diction. He omitted the beginning and end consonants of words. He was restless and quick moving.

Comment

Billy showed most of the common physical and mental characteristics of mongolian imbecility. The diagnosis of this condition depends upon the presence of severe mental deficiency with a selection of the anomalies noted in Billy's case. Most weight should be given to general conformity and appearance, and the diagnosis should not be made if there is any doubt.

Mr. and Mrs. L. spent much of their energy fighting the diagnosis because at the outset they were not helped to assimilate the idea that their boy would never be normal. They remained resistant to all counselling. In early adolescence Billy had to go into an institution; too much was expected of him at home and he became negativistic. Mr. L. developed peptic ulcers, and Mrs. L.'s patience was so exhausted by Billy that she became increasingly severe with Edna, who grew so anxious that she had to be sent to a residential school for maladjusted children where, with wise handling, she recovered. Much of this family's suffering might have been prevented had it been possible to help them to a more realistic and constructive attitude from the start.

Chapter 5

Parturition

As in the case of gestation, in considering the psychological problems arising out of parturition we are concerned with general atmosphere and with the traceable after effects. The actual events are topics fitter for works on pædiatrics and mental deficiency.

The intensity of the physical and emotional experiences of the mother is often used as an argument against painless childbirth. It is said that suffering will increase the mother's feeling for her baby, that as a result of her suffering and danger she will feel an upsurge of instinctual love for her infant on seeing him and hearing him cry. This may be so, but the evidence is not convincing that the wide application of analgesics and twilight sleep and of relaxation techniques, has made modern mothers any less maternal. The contrary may equally be true: modern mothers may be less tense, less frightened and less subject to preoccupation with self-preservation. They may be more receptive to the baby and more able to devote themselves single mindedly to him.

It seems likely that the attitude of the mother to her new-born baby will be determined more by her emotions during pregnancy than by pain during labour. Mature, highly integrated women, supported by their husband's love, often remark with sincerity that the whole experience of labour was keenly enjoyable—a tremendous cathartic experience that left them relaxed and at peace with the new baby. The mother may not, strictly speaking, 'enjoy' her pains but she may repress the memory of their intensity within a few days. To a mature woman a cathartic experience is not necessary for instinctual fulfilment; much of the essence of civilization, of the modification of primitive instinctual patterns, is implicit in the comparative freedom of the mature human being from dependence upon direct sensory gratifications.

Matters may be different in the case of the emotionally immature woman who has rejected her pregnancy. For her the danger and discomfort of labour may be 'the last straw that breaks the camel's back'. One can hope that in her case the cathartic experience may act as a metaphorical evacuation of pus from a psychological abscess, leaving the mother cleansed and able to rebuild healthy relationships anew. But to pursue the analogy, to open an abscess does no more for healing than to provide more favourable local conditions, and in the psychological sense, too, healthy influences are needed if relationships are to be rebuilt.

When a neurotic woman rejects pregnancy, her conflict can scarcely resolve with childbirth. Perhaps the commonest outcome will be overcompensation by the mother. Her 'upsurge of maternal feeling' will make her over-anxious, over-solicitous, worrying about her competence, and unreceptive to the baby's signals. There is danger of vicious circle formation—the mother's tenseness makes her poor at supplying the baby's needs, which provokes unfavourable reactions in the baby, which in turn increase the mother's tenseness and incompetence. Another neurotic mother may have a drive to extract as much instinctual gratification as she can from the situation, maybe by excluding her husband and everyone else from the relationship, and by keeping the baby helpless and dependent upon her.

It is uncommon for a married mother to reject her baby openly; more commonly rejection will be submerged in overcompensation. Open rejection is not common even in the case of illegitimacy. Some incompetent mothers will prove unteachable, which may be tantamount to rejection of and withdrawal from responsibility; or rejection may be disguised by rationalization. 'This is no place to bring up a baby in,' the rejecting mother will argue, though this reaction may be a reflection of lack of acculturation, as in the case of some London Irish labouring families that have not taken to London life and who send their babies 'back home'.

Another form of compensated rejection is the 'martyr' reaction, shown typically in prolonged ill-health of the mother. She 'never seemed to get quite right again', and minor gynæcological repairs give substance to her complaints. She tends to glory in her troubles and to reject assistance; and her husband and children may have much to put up with. Such mothers are 'ever so' devoted. Lastly, an uncommon but particularly pernicious form of reaction is that of the narcissistic mother (see also Chapter 4) who excludes her husband from all share in parental relationships. Childbirth to her may be unbearably sordid, and in compensation, she will become precious, romantic and holy about motherhood. She will be intolerant of the messiness of maternal duties and her child may become obsessional too.

THE FATHER'S PART

Fathers are commonly overlooked in discussions of childbirth. The American anthropologist, Dr. Margaret Mead, once remarked that one might conclude from modern discussions about maternity and child welfare practices that the baby was the joint production of the mother and the public health service! Pregnancy can be a period of preparation for fathers as well as for mothers. The husband who shares his wife's experiences has no need of the emotional tensions of labour to bring him into tune with her. Where there is less identification, the wife's suffering and danger may effectively harness the father's affect. His impulse to share may be frustrated during his wife's labour, though some midwives make use of the husband's services during labour,

fetching and carrying, supporting his wife, helping with the analgesic, and so on. The wisdom of this must be determined by the quality of relationship between husband and wife and, of course, by the feelings of the midwife. Many young British mothers do not know how to secure the support of their husbands during the baby's early infancy, and the husband's need to contribute his share is commonly frustrated.

THE BABY

In Chapter 4 doubt was cast upon the baby's capacity to record, much less recall, the experiences of uterine life. The uterus sets basic conditions of life against which, all later experiences represent change. Further, maternal care will re-create many of the conditions of uterine life for the baby in the early months. Birth is a brief interlude unlikely to leave memory traces; but unfortunately much somatic damage may be done.

The psychology of birth injury is that of the resulting handicap, which like all injuries to developing organisms, will be harmful not only by the absence of particular functions, but also by the distortions of development that such absence will cause through the unbalanced action of undamaged functions and through compensating mechanisms.

Spasticity is one of the commonest sequelæ of birth injury, but no systematic study has yet been completed of the wide panorama of its emotional and other effects. Spastic brain injury was first recognized in Little's disease—a spastic quadriplegia associated with mental deficiency and, sometimes, epilepsy. More recently it has been realized that brain-damaged children are not necessarily mentally handicapped, but in spite of claims made by well-wishers, extensive brain damage in tiny babies is likely to be associated with reduction of intellectual capacity. It happened that two of the four brain-damaged children discussed below were brilliant and the other two were above average in intelligence, but this was due to the selection of cases to illustrate important child guidance problems. Spastic children are prominent among the educationally subnormal; perhaps a large majority are below average in intelligence and very many are mentally defective.

The main cause of brain damage to new-born babies is cerebral anoxia, with resulting destruction of neurone cells. This may be due to foetal hæmolytic disease (see Chapter 4) or to mechanical damage during the process of birth. Hæmolytic disease of the foetus will cause multiform damage; destruction of erythrocytes will reduce the oxygen carrying capacity of the blood; deposits of hæmoglobin breakdown products will collect in the brain tissues; and red cell debris will block the fine arterioles of the cerebral cortex. As the tissue degenerates, the vessels become fragile, and multiple minute extravasations of blood-cells, debris and plasma, and deposition of bile-pigments will occur.

The precise nature of mechanical brain damage is less certain. Almost

certainly the use of forceps has little to do with it, except that forceps are more likely to be used in cases of prolonged labour. Contributing factors may be multiple. First, prolonged labour may interrupt the placental blood-supply long before the birth, and the child will be born in white asphyxia. Second, excessive moulding may tear the meninges and cause hæmorrhage. Subdural hæmatomata may do little harm because of the elasticity of the foetal cranial vault, but subtentorial hæmorrhage into a more rigid structure may result in cerebellar, brain-stem and bulbar damage. Third, succeeding periods of intense pressure and relaxation due to uterine contractions while the foetal head is in the birth canal may cause local effects around the brain arterioles. Pressure on the foetal head will cause a reactive rise in the foetal blood-pressure. The passing of the uterine contraction will result, momentarily, in a state of high pressure within the blood-vessel and lower pressure without. Petechial extravasations of blood-cells and plasma will occur, and neurone cells will be destroyed through lack of oxygen. Fourth, there may be some fragility of the blood-vessels. Premature babies, in whose case the labour may be easy and the pressure hazards small, are particularly prone to birth injury, possibly due to fragility of the blood-vessels.

The effects of damage will depend upon its site. The cells of the cerebral cortex have the double disadvantage of being in the most vulnerable position and of being largely irreplaceable. Hæmolytic destruction may cause a relative congestion of the mid-brain areas and so cause more damage in those parts but there is likely to be widespread damage and the motor area will not escape. In the case of pressure damage the reverse may be true, and the parietal areas of the cortex may suffer the greatest stress, though raised foetal blood-pressure will cause more ubiquitous damage.

The pyramidal tract will naturally bear the brunt of any motor damage, but its full extent will not be revealed until after the completion of the myelination of the tract during the second year. Severe birth shock may cause some temporary flaccid paralysis and, later, release phenomena may appear, pertaining to the extrapyramidal system and to the mid-brain nuclei. The fully developed clinical result is a mixture of spastic paresis, extrapyramidal unsteadiness and rigidity, and primitive mid-brain movements (choreo-athetosis). Legs tend to be affected worse than arms, and interference with the finely skilled movements of fingers may go unnoticed, as our cases will illustrate.

Although the full extent of spasticity cannot be assessed for 18 months—and later in the case of a severely retarded child—the amount of recovery from severe paralysis that some children will show between the ages of 2 and 6 years can be extraordinary. Recovery from pyramidal tract damage can be considerable, and may be almost complete in the case of extrapyramidal and mid-brain damage. The latter is particularly responsive to training. Therefore, care is necessary, neither to allow the parents to get a sense of false

security, nor to be hopeless in the case of a paralysed child of good intelligence. Partial deafness and visual defects are other common accompaniments of spasticity that may be overlooked.

The psychological concomitants of brain damage are various. Impairment of intellect is a function, roughly, of widespread damage of the frontal cortex. There may be nothing to distinguish the resulting defect from that due to congenital germ plasm failure. In addition other aspects of cognition may suffer from defective 'feed-back' of motor-learning experiences. Motor handicaps may interfere with proprioceptive sensation so that the child is uncertain in the judgment of space relationships and of movement. The common combination of visual defect with motor damage may give a specific quality to the cognitive retardation, and result in defective percept and concept formation.

Affective difficulties are less commonly direct. Pronounced mid-brain damage may alter emotional expression. The children will be unresponsive to subtler emotional influences, and their response appreciably delayed, but once initiated, will be excessive and prolonged, tending to irradiate through much of the body. The author once ill-advisedly told a poor joke to some choreo-athetotic boys in a workshop. The joke was received in a dead silence that was suddenly broken by roars of uncontrolled belly laughter which caused them first to double up and then to roll off their workshop benches on to the floor. They lay laughing helplessly, gasping for breath and with tears running down their cheeks! Such an excessive response is often mistaken for emotional lability, which is quite different.

The emotions may be indirectly affected by brain damage, through frustration and uncertainties. Everything will depend upon the quality of parental care, as our cases will show. Most parents will make allowances for paralysis, though it is hard to steer a middle course between too much and too little help, either of which may have the effect of reducing the child's effort for himself. In the former case the child's initiative is not stimulated and in the latter case discouragement may ensue. It is more difficult for parents to make due allowances for the emotional peculiarities of the mid-brain damaged child, and to provide the monotonous, repetitive learning experiences that these children need.

One curious characteristic of some mid-brain damaged children is demonstrated by Michael L. (5). The motricity of mildly paralysed brain damaged children is characterized by rigidity, repetitiveness, inability to change direction quickly, perseveration, and persistence of archaic forms of movement. Some of these children show a curiously similar rigidity of thought process, an inability to switch their minds, perseveration, and general over-control punctuated by episodes of loss of emotional control. Possibly this pattern is due to cognitive compensation for faulty 'feed-back' during the process of space and social orientation. It is most apparent in more highly intellectual

children with very slight paralysis, and it can be a seriously disabling handicap that needs very careful handling.

EXTENSIVE BRAIN DAMAGE

Paul Y. (2) 4.8 years

Paul was referred by the hospital Pædiatric Department. The referral letter stated: 'He was premature, birth weight 3 lb. 2 oz. He probably had kernicterus of prematurity as he was severely jaundiced for 14 days and now has mild spasticity of the legs, and is apparently mentally retarded.' His mother complained of his restlessness and extremely indistinct speech.

Paul lived with his father and mother, brother of 10 months and maternal grandparents, in a small suburban house. It transpired later that Mr. Y. was only a night lodger; he had been a post-war Czech refugee, a schoolteacher who now had a small business. Mrs. Y. was English. The household was unique for its noisiness. Mrs. Y. had an extremely loud and raucous voice and she talked incessantly. Either radio or television were on all day at their loudest, no one ever wanted quiet; everyone shouted in order to be heard.

At the first home visit Mrs. Y. ignored a request to talk with her alone and expected Paul to sit still on her knee while she talked. The first impression was of her hostility to Paul, but later observation revealed that she was passionately attached to him in her egoistical way, though ambivalent. In fact she loved only him, not accepting the baby; but apparently she had been very cold with Paul during his infancy.

Paul was a wanted baby. Mrs. Y. was 25 years old; uneventful pregnancy except that labour was 11 weeks early and lasted 12 hours. Early feeding was difficult and breast feeding failed (with both children.) Paul thrived moderately on the bottle and weaned without difficulty at 12 months.

Motor development was very retarded. He sat up unsupported at 23 months, but walked alone within 2 months. He walked on his toes, was very clumsy and fell a great deal. He did not look where he was going. 'He was making sounds that were fairly distinguishable as words by 2½' but speech developed remarkably slowly. He was left handed.

Mrs. Y. said, 'Paul was never a cuddly baby and no more is my other child.' He would bang his head against the cot and rock himself (the baby did this too). He was extremely restless, never settling, continually fetching things from cupboards, poking into things and interfering. He enjoyed dressing up and would mimic the television. He had fits of apparent frustration, would cry and 'smack his face all day long'. He developed curious rituals and attachments, e.g. he kept an iris root in a paper bag which he took to bed.

Paul was indifferently kind and cruel to the baby. He was at his best with his father, liking to be with him and copying him. Mrs. Y. said, 'he likes to be with men rather than women'. Apparently she never left him alone, but constantly interfered with whatever he found to do in his boredom. She smacked him for restlessness and then remarked, 'he has enough go in him to stick up for himself and smack back'. When a friendly social worker devoted her attention to him, he responded and called her 'Mummy'.

This mother completely lacked receptiveness towards Paul and understanding of his needs. Her biggest concession to his feelings was 'Life has been hard as we always have it' (pointing at Paul) 'with us'. She complained that he could not mix because of his speech difficulty: 'He does not seem to want to hear you; he is just stubborn and will not listen.'

Unfortunately this family was an emotional desert. Family life was incredibly noisy. The grandmother presented some warmth and comfort to the children, but the grandfather would shut himself away as much as he could. Mr. Y. stayed out as much as possible and sustained practically no emotional contact with his wife.

Examination

Paul was friendly, but restless and seemed unused to doing what he was asked.

Merrill Palmer Scale for Pre-School Children: Chronological Age (C.A.) 4.9 years. Score 64. Mental Age (M.A.) 4.1 years. Percentile Rank (P.R.) 20th percentile; σ value — 0.5 to — 1.0.

Paul was not using his potential to the full. Language tests could not begin. His speech followed normal inflections, and sounded almost normal but could not be understood.

Paul was a normal-looking, red-cheeked little boy, but he had a fixed, unvarying facial expression and his mouth was permanently half open. He had a very clumsy, wide-based gait and raised his feet. Motor movements tended to irradiate into his arms and his face, causing grimacing. Other grimaces had nothing to do with movement. When walking he held his hands rigid and arms half flexed in front of him.

He could not negotiate stairs and would have fallen but for support. His behaviour was purely impulsive. Toys excited him, he showed flashes of comprehension, but no sustained interest: e.g. he put a pair of lead tigers together in the sandtray, made an enclosure out of sections of fence, left the tigers outside and abandoned the idea. He appeared to associate a large doll with his baby brother. He played almost obsessively with the dolls' tea set.

He showed marked echopraxia, compulsively copying gestures. His speech sounded vivacious and reproduced tones of voice, volubly; but except for isolated words it was incomprehensible. He did not respond to simple speech but watched the speaker's face and responded to his name.

After Paul had left, he returned to the consulting room, saying 'goat, goat', and reappeared bearing his forgotten overcoat in triumph.

Mrs. Y. was exceedingly tense, with many facial tics and other jerky spasms. She particularly commented on Paul's 'clumsiness'.

The interim diagnosis supported by neurological findings was of brain damage. He had a slight pyramidal lesion affecting both legs. In the arms the lesion was less in the pyramidal and more in the extrapyramidal system. His set facies suggested mid-brain involvement, and there was also a question of deafness. In addition there was a more subtle relationship defect which had impaired his capacity to discriminate between the quality of environmental objects. He was seriously handicapped in discriminating between human and non-human objects, and in appropriately responding to different people. There were related deficiencies in conceptual organization of environmental experiences, shown by perseveration and obsessional or ritual

behaviour, which had largely replaced spontaneous reaction to the external reality situation.

It was further concluded that Paul's lack of orientation was also partly due to his prematurity and his mother's tenseness in a disordered and chaotic household. Both children had shown evidence of withdrawing and dissatisfaction, in head-banging and rocking.

By way of therapy an attempt was made to support the mother and to secure more demonstrative handling for Paul. Even at this late age it might still be possible to secure for him pleasure in his own body and in bodily movements. He was sent to an occupation centre for mentally retarded children in order to introduce him to group learning experiences.

After 6 months in the occupation centre Paul was retested on the Merrill Palmer Scale: C.A. 5.4 years; M.A. 5.10 years; P.R. 60; σ 0.0 to + 0.5.

Even allowing for the unreliability of the test at this level, Paul seemed to have benefited from the organization of his experience that he had gained from the occupation centre. His performance level was at least average. He showed good perception for figure and space and was fast and accurate at the Seguin Form Board. He was successful in picture puzzles and form matching. Apart from repeating certain words like 'daddy', 'dolly', 'boy', etc., while looking at the examiner's face, his speech was still mainly incomprehensible.

This test result again raised the question of deafness, though the occupation centre supervisor had not suspected it. There he was very active with creative materials, and was unusually imaginative. It was reported 'Paul quickly makes a good relationship with other children and often embraces them. His play is very dramatic, and when provoked he tends to bite . . .'. This description would be more appropriate for a child of 3 rather than 5, but it was certainly 'progress'.

Paul stopped developing verbally; so that his hearing was specially tested. The aurist reported: 'His hearing is far too good to account for his speech difficulties. I am sure that he hears everything and that his difficulty is in sorting things out.' Mrs. Y., too, was convinced that he could hear.

Paul was seen again 6 and 12 months later. His hyperkinesis was phasic and related to frustration at home. Amphetamine helped to calm him a little. His spasticity progressively improved, and by 7 years of age was only a certain angular clumsiness. He still did not pay attention to speech unless some device was employed to rivet his attention. His mother used a sibilant hiss for this purpose. He was still unresponsive to subtle social influences and had very limited understanding of interpersonal relationships.

Retested on the Revised Stanford Binet Intelligence Scale Form L (R.S.B.): C.A. 6.10; M.A. 5.0; IQ 73. Although more amenable, he quickly became negative when in difficulty. On verbal tests he was below a $3\frac{1}{2}$ year level, but in visuomotor tests, up to his life age.

Raven's Progressive Matrices 1947, score 21 (with an additional doubtful 4). At age 7, the 50th percentile is 16 (but at low scores the chance factor is rather high). He controlled his pencil well and showed accurate observation when not distracted. He knew a few letters but was uncertain about right or left direction. He was left handed.

Paul's progress in speaking was disappointing and his teachers were convinced of

his deafness. Clinically it seemed likely that partial deafness was interfering with his learning, which was slow and patchy. Audiometry was carried out three times by a specially experienced tester. The report left no doubt that Paul was quite severely deaf for the important speech frequencies. The aurist noted 'superficially there seemed to be other difficulties superimposed on his partial deafness', and recommended transfer to a school for the partially deaf, and a deaf aid.

Comment

Paul's history indicated that his difficulties were scarcely 'superficially superimposed' on his partial deafness because, clearly, his difficulties covered a far wider field, and they had appeared at an earlier age than could be related to deafness.

Though Paul had made a considerable recovery from his diffuse brain damage, he had been severely handicapped during the important toddler motor learning period when quality of maternal nurture will greatly affect the confidence of the child's behaviour. With adequate bodily comforting the child learns to move confidently and skilfully, and to relate his bodily experiences to his feelings of satisfaction and dissatisfaction, and both of these to his interpersonal relationships as experienced through his mother (see also Chapter 9). Paul was extremely deprived in these respects.

In addition, Paul's motor handicap made the control and learning of motor skills very difficult for him, and his proprioceptive deficiencies impaired his confidence. Mrs. Y. oblivious of his real needs, failed to make things right for him, and he ceased to turn to her for intimate support. When Paul started to learn to talk, Mrs. Y. never spoke to him in less than a roar. He got none of the little endearments that warmly reward the effort of listening to mother and trying to understand her. She worked hard to entrap his attention and succeeded in communicating with him, but it was a crude process on both sides. He had some inkling that talk *meant something*, as his accurate though meaningless mimicry of talking showed. The aurist's recommendation of a school for the partially deaf was reasonable, for the more his intellect was harnessed to listening the better, but it was doubtful whether he could accept the school situation, however modified, without specially preparing his teachers to meet the repercussions of his emotional immaturity. Finally, the impression of autism was largely illusory, since lonely and unsupported children will often resort to autistic mannerisms.

PYRAMIDAL DAMAGE

Alan T. (3) 10.5 years

Alan was referred by an orthopaedic surgeon who thought that Alan was too nervous and excitable to withstand operation for lengthening the tendo Achillis, but needed help. A neurologist reported: 'Alan has mild infantile spastic cerebral palsy with a bilateral equinus deformity and considerable shortening of tendo Achillis and hamstrings. His bedwetting and tics are due to emotional causes rather than the diplegia.'

Family History

Mr. T. was a one-time missionary turned schoolmaster; a devout, serious-minded

man of 55 years. Although humble and over-conscientious he was wordy and obscure, and frequently was thought to be difficult, pompous and impossible. Mrs. T. was a little overburdened by the family troubles. Alan's 14-year-old sister likewise tended to be misunderstood and suffered undeservedly for smugness and ungenerosity. Their house was too big and they were financially embarrassed.

The parents said that Alan wetted his bed nightly and was very backward at school. He was dreamy and slow except with his own employment. His co-ordination was poor, and he dropped and bumped into things. Active games were impossible for him. At home he was touchy, easily offended and bickered with his sister.

Mrs. T. was a poor informant because of inhibition, but she maintained that the first hint of difficulty was at 12 months when they took him to a children's hospital because he could not sit up unsupported. But she said that he walked by himself by 15 months, and had a 'childish trick' of walking on the balls of his feet. From then onwards he had much orthopaedic treatment for his leg condition. He started nursery school at 4 then passed through 6 schools, due to family moves. His latest school report stated: 'English fair; arithmetic very backward indeed; manipulative skill and handwriting very poor. He is supposed to be musical but has acquired no skill. Does not want to really work. Extremely sociable and friendly. A very nice little boy but most dependent upon grown-ups. The children like him and accept him. His home distracts him with late nights at choir practice, choral society and other church week night functions.'

Alan was something of the 'little old man' but was not timid. He was sociable, though with little free and spontaneous dealings with his contemporaries. He seemed to prefer old people, and he joined in his father's religious good works whole-heartedly.

Examination

R.S.B. Form L.: IQ 116; Weschler Intelligence Scale for Children, Performance IQ 80. He was slow and methodical in speech, with a somewhat elephantine playfulness. R.S.B. scatter from 8 to 14 years inclusive. Vocabulary well above age level; his definitions tended to be expansive. His first failure was at paper cutting (9 years); apparently he could not cope with orientation. He was good at memory tests involving analysis and resynthesis of visual patterns, and showed considerable powers of concentration.

At a second visit Alan invited the psychologist to tea in return for services rendered. Raven's Matrices, Category B; he was conscious of perseveration: 'I keep putting sevens,' and 'I can't help putting brackets'. His drawing of a man was immature and showed an asymmetrical deformed person walking on his toes; no limb detail. Bender visual-motor gestalt drawings showed great immaturity, particularly motor. He was uncertain when shapes were superimposed. In a simple sorting test involving colour and shape, he perseverated with Bender gestalt patterns. He could not classify by colours. Schonell Graded Word Reading Age 12.4. After reading eight lines horizontally, he read vertically without noticing. He had a slight spelling disability. Right handed and left eyed.

At clinical examination Alan was pale and undersized, with the physical develop-

ment of a 7-year-old. He was cheerful, but had a severe blinking and grimacing tic, worse on the right side than the left. He was short-sighted. His movements were clumsy, but he managed stairs quite well. He had a mild spastic weakness of the right leg, and a doubtful lesion of the left. The right tendo Achillis shortening was such that he had to tilt the pelvis to get his right heel to the ground.

In contrast the right arm seemed unaffected, but he had a distinct spastic weakness of the left forearm and hand, with clumsiness of hand movements, increased tendon jerks, slight intention tremor, and lack of skill in fine movements. He tended to protect the left hand by the right. He had a slight hesitant stammer.

He showed a mixture of childishness and 'old fashioned' qualities, apparently being more at home with adults than with children. He said he liked being examined and was very interested in every procedure. He said 'Excuse me if I appear to be personal, but how long does it take to train to be a doctor? . . . I've always wanted to be a vicar, but when I've become that I might become a doctor as well.'

His conversation was slow, heavy and perseverating. Somehow he became interminably involved in talking about other universes and whether there was human life on those stars that had atmosphere.

Mr. T. acted as though he felt it almost a personal affront to have to suffer these misfortunes, yet his high principles made him wretched about his feelings. He appeared to have repressed consciousness of Alan's neurological handicaps and it was probably this that had prevented this conscientious father from attempting to secure suitable education for Alan.

Alan had clearly been brain damaged. It is possible that he was naturally left handed and that having to depend on his right hand had increased his motor frustration.

Alan's mental state was suggestively like his physical condition. His physical clumsiness was due to a combination of failure of the higher co-ordinating motor mechanisms, the persistence of archaic motricity and conscious or near conscious efforts to compensate. As remarked earlier, it was almost as if the same had happened on the mental side, for his mental processes were slow, unadaptable and perseverating.

Comment

The immediate problem was the pressure to which Alan was being subjected. At school a superior level was demanded of him, though his motor handicaps were making school learning very difficult for him. With an R.S.B. IQ of 116 and a W.I.S.C. Performance IQ of 80, it was little wonder that he retired behind the use of words he imperfectly understood.

Alan's problem subsequently fully taxed the community's therapeutic resources, with a very moderate result. The first lesson to be learned from Alan's troubles was that appearances may be deceptive in the case of brain damage. The neurological lesion was not severe. Increased co-operation and exercises gained a tolerable result without the tendon lengthening operation. Confidence and practice achieved more. An imaginative schoolmaster, finding that he could not change direction of movement quickly enough nor see the ball clearly enough to play soccer, put him in a rugger pack where, though unskilful, he gained enough satisfaction to feel acceptable and accepted. This was vital for him. But so long as he was expected to compete

academically with non-handicapped children and to achieve higher than normal standards of behaviour, his position was hopeless.

Appearances were deceptive because his motor clumsiness during the vital second year motor learning period had deranged his whole movement pattern. With a faulty 'feed back', he was deeply uncertain about movement, and had attempted to correct by rigidity which had led to unadaptableness and perseveration. Short sightedness contributed to his orientation difficulty. A vicious circle of unconfidence and maladroitness had caused a degree of disability quite disproportionate to the amount of neurological damage.

The second important lesson was that a difficulty can be increased by good intentions and high moral principles. With extreme conscientiousness Alan's parents made allowances for his obvious difficulties—overpraised him for some of his achievements, but failed to understand his more subtle difficulties: treatment which made him strive to gain adult approval and left him unhappy about being a boy. Thus Alan had become priggish and impossible in many ways, which was resented by other boys who had no idea of the extent of his disabilities. Alan was distressed by his unpopularity and tried hard to gain acceptance by doing the things for which he was praised at home. An unsympathetic schoolmaster saw only a boy of mediocre ability and moderate industry, who was rather servile, trying to curry favour, priggish and not above tale bearing.

The querulous insistence of Mr. T.'s demands, coupled with his genuine attempts to be reasonable and grateful had the bizarre result of irritating those disposed to help, though Alan's need was never in dispute.

Brian Brown (4) 7.3 years

The family difficulties of the Brown family are discussed in Chapter 16 (pp. 379–384); here we shall be concerned with Brian's handicap from birth injury.

Brian had been a premature baby. He had a slight spastic paraplegia affecting both legs, some incoordination and slight athetosis of the hands and fingers, worse on the right side. He was right handed and right eyed. Both hip joints were internally rotated, his left ankle inverted to bring his weight on the malleolus.

Brian had had an enormous amount of out-patient orthopaedic treatment. At 5½ he was away for several months with a serious mastoid operation, during which time his youngest sister was born. Upon return he was unhappy and resentful.

When he was 7, the surgeon was planning special finger exercises, piano-playing and typewriting, to help Brian with fine finger movements; but he received no understanding at school where the weakness of his hands had not been connected with the 'painful slowness' of his handwriting. There he was considered lazy and his mother as doing too much for him.

Brian's intelligence test result was IQ 148, in spite of clumsy finger movements, slow speech and difficulties of passing rapidly from one idea to another.

Brian had a stable personality but his gentle, out-turning temperament concealed a great determination. But he needed protection, partly because he compensated so well that his handicaps were not noticed by the undiscerning and he was exposed to too severe competition; and partly because his mother's over-anxious drive pressed him too hard and also alienated key officials who were trying to be helpful.

Therefore, in spite of his very high intelligence, Brian's slight neurological handi-

caps were far greater than they appeared even to those who knew him well. He never constituted a psychiatric problem but his family difficulties occupied an appreciable proportion of the time of a Child Guidance Clinic for more than eleven years.

SOME SUBTLE EFFECTS OF BRAIN DAMAGE

Michael L. (5) 6 years

Michael lived with his parents and sister aged 3 and brother of 6 months in a comfortable London flat with access to a garden. Both parents were university graduates. Mr. L. had been an economics don, who after distinguished service in a wartime ministry, had successfully entered commerce. This had left him dissatisfied, and he was trying to find a way back into academic life without reduction of standard of living.

Mrs. L. had also given up university work, on principle, in order to look after her young family. She was, however, bidding fair to becoming a perpetual student.

The L.'s were a united and spontaneous couple, they believed in equality for all members of the family: in sharing work, responsibility and pleasures, and in respecting the children's individuality, needs, and rights.

Their first set-back was a still birth after 2 years of marriage. Mrs. L.'s happiness during her second pregnancy was tinged with anxiety about the outcome. Labour normal; 9 hours second stage; birth weight 6½ lb. The baby was severely shocked and had white asphyxia. Breathing was established with difficulty. Michael was nursed in an incubator, and pipette fed with expressed breast milk. He developed severe kernicterus.

After a crisis lasting 3 weeks, Michael did well under his mother's very watchful eye. He was sluggish, a slow feeder and with little movement, but he was receptive, smiled early and watched what was going on. Fortunately Mrs. L. did not take advantage of Michael's undemanding nature to leave him in his cot or pram for hours; instead she wanted to enjoy her babies and she devoted much time to talking with him and stimulating him.

He sat up late, moved little, and showed little interest in handling toys. With persuasion, he crawled at 15 months, and walked at 18 months with both hands held. He enjoyed passive movement. He walked alone at 2, with a wide staggering gait, which he did not lose until 4. He was still ataxic at 6.

Weaning was easy; Mrs. L. skilfully never allowed Michael's slowness to impair her serenity; and the same with toilet training, between 3 and 4 he gradually became dry at night. His movements were badly co-ordinated and he appeared very uncertain of the position of parts of his body, and was unable to predict the result of a movement.

He was forward in talking. He mimicked talk volubly at 12 months, and by 2 years could use short sentences, though with lalling and substitution of consonants. When he started developing a private language with his toys his parents devoted themselves patiently to talking with him.

It was Michael's talking that kept the parents from thinking that he was mentally defective. Mrs. L. assiduously read volumes on child development and was little comforted by doctors' casual reassurance. All parties were helped by Mary's birth

when Michael was 3. In spite of natural anxieties, Mary was normal, and happy. Michael had insufficient perceptiveness to become jealous, but helped his mother, clumsily. In a relaxed atmosphere he gained in confidence, perception, and conceptualization of ordinary things and happenings.

At 6, Michael was tall, thin and fair-haired with a clear, pale complexion, a set face and eager eyes. He had a hypotonic musculature, thin arms and legs, ungraceful posture and a jerky clumsiness of movement. He was friendly and a wide grin would suddenly split his face and, after a pause, would be wiped off again. His gait was ataxic, he lifted his feet high and planted them widely when walking, swaying from side to side and bumping into his companions. He would talk incessantly, reminiscences or abstract remarks unconnected with the present. Though apparently paying no attention to where he was walking, he would stop at a kerb or obstacle, give all his attention to the problem and overcome it with exaggerated movement. He was not timid, but joined in group games with enthusiasm and utter lack of skill.

Michael had a very high-pitched, shrill voice, unmodulated in pitch and volume. He pronounced his words slowly, with an effort, and slightly separated them. He used a large vocabulary, but was prolix; it appeared as if he had been talking for all eternity and probably would never stop.

Michael had good understanding at home, based on mutual love and tolerance. He was naturally out-turning and had a strong urge towards society. In all relationships, whether with human beings alone or in groups, with animals, material objects, space or time, he seemed not to notice anything unless he gave his conscious attention to it. Since his consciousness was greatly taken up with abstract thought and fantasy, he was socially insensitive and unsubtle. This made him appear to be withdrawn and self-centred, which was very far from the fact.

Michael's problems at school were serious. Though he could read quite well he still could not tie his shoe laces or put on his overcoat. He was a slow, messy eater and spilt his food on his clothes. He was clumsy in his movements and a complete ninny at games. His ability to read left him bored and inactive while the others were learning, and his motor babyishness made him a figure of fun. Happily he was too insensitive to notice the ridicule, and his balanced, secure nature never imagined that the laughter of others was hurtful. He threatened no one and was kindly, friendly and generous; so that the laughter became kindly and his disabilities brought out the best in the other children. However, he was lonely. He tried hard to keep up with the others but he could not adapt to a rapidly changing games situation and inevitably spoiled the game. The others tended to exclude him.

Michael had so much going on in his fertile mind and a great drive to overcome this enormous difficulty of self-expression that his social demeanour was very demanding. This was far from the egocentric demand of an out-turning but regressed child. A couple of years later his school mates christened him 'the limpet' and for a while treated him like the club bore.

R.S.B. Form L. IQ 112. He was handicapped in timed tests by slowness. He had poor perception of space relationships; good reasoning and a high vocabulary score. This unreliable test result did not exclude the possibility that he was of superior intelligence. He needed to have special allowances made for his difficulties in learning to write. His letter formation was jerky and included reversals and anomalous shapes. In view of his verbal facility his painfully slow writing frustrated him exceedingly.

His small school handled him very intelligently and learning never became tedious for him. Wechsler Intelligence Scale for Children at 8 years: Verbal IQ 140; Performance IQ 100. He was severely handicapped in timed tests and by his inability to change his mental direction rapidly. He was of very superior potential.

Talking with Michael at the age of 8 was unforgettable. His high-pitched voice and ponderous enunciation went on and on. He never knew when or with whom to launch into an interminable conversation about some abstract interest of his, but when started he went on remorselessly, not noticing any deflection, or if interrupted, picking the matter up again immediately. He asked interminable questions.

In one conversation he quickly disposed of what the other side of the moon looked like, and considered what the sky looked like to someone on the other side of the moon. He wondered whether a watcher on Mars could see the effect on Earth of an eclipse of the sun; and whether with powerful telescopes on some star, people were making running commentaries on the Battle of Hastings.

In spite of such formidable intellectual interests, Michael had a keen sense of fun. Puns and word play delighted him and a verbal absurdity might cause a paroxysm of merriment. He reacted slowly, then suddenly a grin would flash and he would laugh uncontrolledly until tears came. He often looked as if he might fall off his chair with laughing.

There was no discoverable neurological lesion, only his set facies, muscular hypotonia, jerky and ill-controlled movements, irradiation of emotional expression and uncertainty about body position and movements. His mental processes had also an almost Parkinsonian rigidity. The whole suggested diffuse mid-brain damage. It was later discovered that Mrs. L. was Rhesus negative, whereas Michael and Mr. L. were Rhesus positive.

Two points were important to consider in planning Michael's education: first, that postural and movement difficulties related to mid-brain lesions can largely be overcome by conscious training; secondly, that emotionality plays havoc with the capacity of the mid-brain damaged children to control movement, so that to compel such children to conform to a time schedule can have disastrous consequences.

Fortunately Michael's preparatory school respected his individuality and treated his foibles kindly. He was not hurried in difficulty; and he was encouraged in subjects where he excelled, of which mathematics was the most prominent. He was given carefully planned physiotherapeutic exercises, progressing to eurythmics. He was later persuaded, reluctantly, to take up square dancing and even ballroom dancing. He gained greatly in confidence in movement and in body control and hence in pleasure in activity. Ball games were too quick for him, but he enjoyed swimming and was safe on a bicycle.

There was a strong boarding school tradition in the L. family and it seemed natural for Michael to go at 13. A school was selected which combined the social advantages of a Public School with a liberal outlook and individual attention where needed. Michael's harmless good nature ensured his popularity there from the start and in due course he gained University Entrance.

Comment

Michael's success was a triumph for his parents' integration of warm feelings and intellectual grasp of the situation. During his first two years of difficulty in orienta-

tion, maternal passivity, so fatally easy, would have resulted in a permanently handicapped, almost lost little boy. Later, unskilful pressure, or frustration of his real needs, would have increased his difficulty in control. He was treated with the right mixture of stimulation and support; and the whole family benefitted. As Michael grew older the increasing complexity of his intellectual capacities resulted in a steady improvement in both mental and physical functioning.

Chapter 6

The Establishment of Life

IN approaching the study of the first year of life and of its difficulties and disorders, it will be helpful to review the main developmental features of the period, taking as the starting point the moment when the mother takes over the care of the child in her own home, approximately two weeks after birth.

On page 11 an analogy taken from somatic embryology illustrates four principles upon which the development of the embryo depends:

1. an inherent predisposition for the development in question;
2. a matrix of existing development;
3. the presence of adequate nutritive materials; and
4. the presence of a biochemical 'activator'.

These four conditions must all be fulfilled before any new embryological development can take place. It is equally essential that all of the conditions be met within a certain limited span of time and at a period that is appropriate to the developmental pattern of the species.

Applying this analogy, as discussed above on page 11, the necessity for a predisposition is obvious. Equally, nothing new can appear without a basis on which to form. For example, the baby's capacity to conceptualize 'the mother' will depend upon the possession of the necessary perceptual apparatus. Thirdly, 'nutrition' in this case will be environmental experience: the mother concept will form partly out of the baby's experience of being mothered. Fourthly, the 'activator' will be represented by the intimate details of the mothering experience—the appropriateness with which the mother treats her baby. Thus, in an analogical sense, these four principles in operation within a limited span of time and at the proper period of the baby's life, will all be necessary. Without any one of them, subsequent psychological development either will not take place or else be subject to distortion.

The new-born baby's equipment is considerable in extent and complexity but very limited in range. During foetal life an important co-ordination and organization of the circulatory system has taken place. Immediately at birth, the process of blood oxygenization is transferred from the placenta to the lungs; and that of nutrition to the alimentary canal. Both changes are effected by means of inborn reflexes, the result of inherent growth processes, without which the baby could not maintain life. The two reflex systems differ in that the respiratory reflexes remain largely outside conscious control, while the

alimentary reflexes later become subject to much conscious modification.

Apart from the complicated organizations which serve circulation, respiration and nutrition, the baby is neurologically unorganized. His movements are primitive, uncoordinated and chaotic, and he has no special sensory perceptiveness. Functionally the baby is blind, deaf and insensitive, though most babies show a phototropic nystagmus to moderate light, and screw up their eyes in bright light. Many will show a mass motor response to loud sounds, grasp reflexes and other archaic reflexes—walking, stretching and startle. These reflexes are without practical significance, other than that their persistence for more than a few weeks is an unreliable sign of retardation of development. The baby's time is spent in feeding, making uncoordinated movements and in sleep. It may be noted in passing that the sleep of a tiny baby merely involves the cessation of mid-brain activity, rather than the inhibition of the fore-brain. Thus babies will 'drop off' with ease, though some appear to sleep very little.

During the course of the first 12 months the child will have been weaned to solid foods and will have begun to feed himself. He will have acquired some locomotion by crawling, and have come to understand the relationships of objects within the area that he can reach. He will have little comprehension of the wider world, and especially, of movement, save for all that appertains to his mother, with whom he should have established a relationship of warmth and considerable complexity. He will show preference for certain toys, will make use of simple tools to gain an end, and will be capable of some simple, practical reasoning. His memory will be quite extensive, and he will recognize and, to some extent understand, the significance of regular daily happenings; he will have a limited ability to communicate needs but practically none to communicate ideas.

In 12 months, therefore, the baby will have travelled far from the ego-centric helplessness of early infancy. The first 3 months are occupied with the establishment of independent life, with orientation in the simple time relationships of babyhood. At first, survival is secured by means of the inborn reflexes, but the baby's regular needs soon become accommodated to the external circumstances. The second phase, from about 3 to 9 months of age, includes first, the child distinguishing his mother from other environmental objects and beginning to enter into a relationship with her—the foundation of later interpersonal relationships. The distinction which the baby makes between a special object in the environment and everything else, will also be the beginning of his orientation in space. Of no less contemporary and far greater later significance is the connection established between external relationships and the satisfaction of instinctual needs. A third phase overlaps the second, and occupies the second half of the first year, in which there are two related happenings: the commencement of modification of the baby's early patterns of behaviour and instinctual rhythms; and the appearance of

aggressivity, its differentiation and the development of primitive control mechanisms. In discussing the normal and abnormal features of the above three phases, it should be remembered that the child is having an indivisible continuity of experience.

THE ESTABLISHMENT OF LIFE—ORIENTATION IN TIME

The baby's first learning is achieved through conditioned reflexes, which are of considerable complexity from the start. Later, when fore-brain activity is established, the conditioned reflex becomes more and more relegated to the automatic and unconscious activities of the mind.

For the first few weeks the baby will give a 'feeding' response only to tactile stimulation of the skin and mucous membrane of the buccal area; but later will respond to other concomitants of feeding, such as lifting from the cot, removal of wet napkins, and caressing by the mother. Even at the primitive level of automatic response, it is remarkable how quickly the new-born child will learn. Sucking and swallowing are not efficient at first, but by the end of the first week, most babies are co-ordinating their movements quite well. As his range of perceptiveness increases the baby will begin to respond to the approach of his mother, but at first only when he is hungry. Later, he will respond to his mother's presence whether he is hungry or not, and the quality of his behaviour will have changed from that of the simple hunger response. By the time this happens he will be in the phase of relationship formation, and the dominance of the uncomplicated conditioned reflex will have ceased.

Maternal care ensures that the learning process is made as easy and as gently graduated as possible for the baby. The rhythms of nursery life in the first few weeks will vary from the standard of constancy established by the uterine environment only within the narrowest limits, in three respects:

- (a) a wake-sleep rhythm;
- (b) a feeding rhythm; and
- (c) a pattern of excretory habit.

(a) and (b) are interdependent and together form the great dominant cycle of baby life, and may be described in six phases:

1. equilibrium, marked by so-called 'sleep';
2. increasing restlessness, 'waking up,' and crying;
3. signs of distress, physical and mental;
4. a 'hungry' reaction to the breast—vigorous sucking, gradually decreasing in *tempo* and force;
5. a short interval of quiet 'wakefulness';
6. return to equilibrium and 'sleep'.

This cycle will recur, perhaps five times in the day, at roughly 4-hourly intervals; but with most babies, after the fifth feed at, say, 10 p.m., there will

be a gap of some 7-8 hours and a further feed not demanded until about 6 a.m. Babies show much individual variation.

We are not here concerned with the relative merits of self-regulation and schedule feeding. The healthy, normal baby will adapt to any feeding routine, provided that it satisfies his needs. The majority of mothers who adopt self-regulation will find that the baby will quickly settle into a regular feeding pattern, not less regular than that of most children on 'schedule' feeding. It is a remarkable fact that the great majority of British babies do not get fed during the night—say from 10 p.m. to 6 a.m., after the first few weeks. Quite a high proportion never have a night feed from the day of birth. What capacity enables a baby to conform to an adult wake-sleep pattern that, owing to seasonal variation is independent of light and darkness, is unknown. This fact should open the mind of the observer to the possibility of other unknown forms of perception being available to the very young baby.

After 3 or 4 weeks of life the baby's reflex smile appears. By narrowing down the stimulus, Spitz established experimentally that the 2- to 3-month-old baby will smile automatically at the sight of the human mask—eyes, forehead, nose and upper lip—in movement, but within his near field of vision. This reaction establishes the baby's capacity to perceive an object in the field of vision, and to differentiate object from background. After about the tenth week, the automatic reflex smile fades and is replaced by a much more specific response—the social smile. In the latter, the child smiles upon recognition of the face of the mother; and in doing so can be said to have embarked upon the formation of his first social relationship.

Undoubtedly the development of the child's perception of external objects is inextricably bound up with feeding. Logically, until a baby can perceive the environment as something distinct from self, he will have no consciousness of self. These two perceptions develop at the same time out of sensory experience, of which that of the baby's alimentary nervous system is highly developed, while skin and proprioceptive sensation are no more than primitive. Let us consider what the five times daily feeding experience may mean to the child.

To adults hunger means discomfort and, possibly, pain; it causes restlessness and an irresistible drive to satisfy the want. Satisfaction of hunger brings, first, the acute pleasure of feeding; and second, the more solid pleasure of a feeling of satisfaction, relaxation and sense of fulfilment. At what age a baby will begin to experience these discomforts and pleasures cannot be determined; but, from the time the child starts 'recognizing' his mother, it is possible that these experiences will begin to come into consciousness.

The behaviour of a healthy 8-week-old baby will suggest that this recurring feeding experience is a powerful one. It is the baby's most frequent regular experience and, having in mind the state of his nervous system, is likely to be the most vivid. Moreover, it introduces him to the form of

emotional experience which is most highly prized in the English culture, viz. mounting tension and its climactic release.

There are strong supporting influences. The hungry baby is lying in his cot, crying and presumably uncomfortable, however dimly this may be perceived. The mother picks him up, makes much of him, changes his nappy, caresses his skin and, most important of all, smiles and laughs with him, face to face. She evokes first his reflex smile and then the social smile of dawning recognition. And all this is inextricably mixed up with an increasingly vivid experience of the discomfort and pain of hunger, followed in turn by the pleasure of feeding and then by satisfaction. The effective mother will not allow the baby's hunger to get too much for his limited capacity to stand strain. When she feeds him, she will satisfy him efficiently and completely. She will communicate with him successfully during the play periods around feeding. In such circumstances, therefore, the child will begin the establishment of interpersonal relationships.

Of the third great rhythm of baby life—the pattern of excretory habit—there is little to note at this stage. The baby's bowels will be opened once or twice a day, or whenever the rectum reaches a certain tension. With regular feeding and a food intake of constant quantity and quality, regularity of bowel action can be expected. Much the same is true of the bladder, which will reach a certain degree of distension every few hours and will empty automatically. As well as the quantity of urine in the bladder, the rate of filling will affect the voiding reflex; but with a constant food intake, regularity will probably result. The majority of tiny babies can be conditioned to micturate when sat on the pot, if the bladder is near the threshold of reflex emptying. Some mothers will be likewise successful with bowel 'training'. The secrets of success are regularity and constancy of food intake, and skill in judging when to sit the baby on the pot. The conditioned reflex that sets off the voiding mechanism probably has nothing to do with conscious control. The possible disadvantages of such precocious toilet training, will be discussed further in Chapter 9.

NORMAL VARIATIONS IN RHYTHM

Naturally babies differ, but in the first few weeks babies vary little, except in the quantity of their behaviour. The hungry baby will show much muscular activity, kicking his legs and waving his arms, moving his facial muscles and his head. He will scream until fed, when his whole activity will become absorbed in feeding until, with diminishing hunger, little bodily movements will reappear. When fed, the baby will lie more or less quietly, showing slight movement and, after a period, will fall asleep. He will lie with a minimum of movement until hunger in due course brings about restlessness again.

Some babies show much more activity than the average. Their waking movements are vigorous and unceasing, and their crying tempestuous.

During feeding they continue to kick and push, and move their heads, often interrupting themselves, upon which their subsequent screams may interfere with the restarting of feeding. Often active babies spend little time in so-called 'sleep', and almost never lie still.

Other babies show far less than average activity. They may sleep right up to the moment of feeding, be hard to rouse, and fall asleep in the middle of their feed. Nurses always describe these as 'lazy babies'. Even their sucking is lethargic, and after the feed they will lie quite still, though they do not necessarily fall asleep again at once.

Babies can be graduated on a scale from inactive, through moderately active, to very active. Once the extreme either of activity or inactivity has been established recognizably in a young baby, it tends to persist throughout early childhood and, indeed, throughout life, allowing for the later differences in normal manifestation of activity. Activity or inactivity in due course may become characteristic of an individual. Naturally, a pattern of behaviour either of extreme activity or inactivity will affect people in the baby's environment and so affect the child's relationship formation and thus his development. This will be for consideration later.

Another basic differentiation is sometimes possible, though with less certainty, in the first 3 months. Reference has been made in Chapter 1 to 'out-turning' and 'in-turning' types of temperament. Individuals vary in the degree to which they tend naturally to turn outward and enter into communication with their surroundings or, alternatively, to withdraw and isolate themselves. In extreme circumstances temperamental peculiarities of this sort may be manifest even during the first 3 months of life.

ABNORMAL BEHAVIOUR PATTERNS

The reactions and thus the development of the baby may be abnormal in the event of three sets of circumstances, alone or in combination:

1. Failure on the part of the environment to provide for the baby's needs;
2. The baby's lack of sensitivity to the environment, with or without a lack of capacity to react to circumstances;
3. An extreme degree of either activity or inactivity.

1. *Environmental failure* may have serious and long-lasting consequences. At first sight serious consequences would appear to follow only a gross failure resulting in a lack of provision for the simple needs of the tiny infant, but there may also be important subtleties. For example, take the case of the premature baby born 'too weak to suck'; or, more accurately, with an immature nervous system in which the sucking reflex is not yet working. Great difficulty may be experienced, first, in getting the baby to take food and then to establish normal sucking. A vicious circle may be established of feeding difficulty, under-nutrition, weakness and developmental retardation, that may interfere with growth throughout childhood and thus affect the whole life.

Very serious results can come from failure to establish satisfactory rhythms of living during babyhood. Maternal mismanagement may be such that the child is not fed when hungry, or insufficiently fed, so that this great learning cycle of early childhood remains unorganized. Children so exposed may experience early difficulty in distinguishing themselves from the environment and thus may lack ability to discriminate between objects in the environment. The mother will never appear to such a child as the guardian angel who puts an end to all discomforts and who brings with her all the pleasure in life.

Lesser degrees of mismanagement, however hard the mother may try to provide for the baby, may bring about lesser degrees of difficulty or disability, of which the one constant sign is retardation in development.

2. *Lack of sensitivity and lack of capacity to react* to the environment, on the part of the baby may have several causes, and many effects. The most common conditions of this type are those associated with mental deficiency (for a description of which, the reader is referred to standard works on that subject. It will be dealt with here only in so far as may be required for differential diagnosis.

Mental deficiency (amentia)¹ can be either congenital or acquired or, as sometimes termed, primary or secondary. Fraser Roberts (1952)² after studying a sample of defectives and their relations, described two main types: those whose deficiency represented the lower extreme of the normal curve of distribution of intelligence in the population; and those in whose case the deficiency is qualitatively rather than quantitatively different from the normal. The former broadly correspond with the feeble-minded (to use the established term, now under criticism), roughly three-quarters of the whole group; the causation, according to Fraser Roberts, being probably a combination of factors. The latter comprise the more severely subnormal and

¹ The terminology used in connection with mental deficiency is now in process of change. The Mental Health Act, 1959, has replaced the terms *mental deficiency*, *idiocy*, *imbecility* and *feeble-mindedness* by two new terms: *severe subnormality*—a state of arrested or incomplete development of mind so severe that the patient is incapable of leading an independent life or of guarding himself against serious exploitation (or, in the case of a child, that he will be so incapable when adult); and *subnormality*—a state of arrested or incomplete development of mind which includes subnormality of intelligence and requires special care or training but does not amount to severe subnormality. The 1959 Act also defines two other terms: *mental illness*—the usage of which is unchanged; and *psychopathic disorder*—which includes the conditions of abnormal aggressiveness and irresponsibility previously referred to variously as *moral deficiency* and *psychopathic personality*. It appears that any term used in any of these connections is bound to become stigmatized in the public mind. To prevent confusion, a minimum of the old terminology is employed in this text on the few occasions on which it is necessary.

² Fraser Roberts, J. A.: 'Genetics of Mental Deficiency' (1952) *Eugen. Rev.*, 44, 71-83.

their causation is ascribed to a single accident, including genetic accidents.

It can scarcely be doubted that social factors contribute to the causation of mental deficiency, although public attitudes to and technical difficulties of making surveys of prevalence and distribution have resulted in suggestive rather than definitive evidence. It is possible that the mental deficiency rate is considerably higher (perhaps double) in that section of the population sometimes designated the 'social problem' group, which comprises roughly the lowest decile in the socio-economic scale.

On the other hand, known—i.e. ascertained—subnormals do not often reproduce themselves. Their opportunities for reproduction will be curtailed by proper social supervision and, in addition, mental and physical inferiority will tend to reduce to nothing both their reproductive activity and their fertility.

The first type of amentia, as defined above, is also sometimes known as *simple*, and is characterized by an all-round backwardness in mental and physical development which arises out of and contributes to a general mental and bodily inferiority, in association with many kinds of congenital abnormality.

Contributing to the second type will be any developmental disorder, degeneration, disease, or injury of the central nervous system occurring before maturity is reached that may impair the growth of psychological faculties. In this event, the extent and location of the damage or disorder, together with the age of the subject and the stage of development reached, will determine the outcome. If the child's level of psychological functioning is reduced to a degree that makes it impossible for him to respond adequately to environmental requirements, society will regard him as a mental defective. The threshold level of deficiency will be a matter of social criteria, e.g. in Great Britain a child of 12 years who has a general level of development of less than 8 years might well be deemed mentally defective.

The commoner causes of acquired amentia include:

- intra-uterine developmental failures, possibly a disorder of oogenesis, e.g. mongolism;*
- birth injury, usually causing structural damage through intracranial hæmorrhage;*
- hæmolytic disease of the newborn;*
- parental blood incompatibility, causing brain damage;*
- fœtal endocrine disorders, e.g. cretinism, pituitary failure;*
- sensory deficiency, especially blindness and deafness, when conditions are particularly unfavourable.*

There is another rare condition encountered in clinical practice, which may lead to a very serious retardation of development and to an atypical form of amentia, in which the baby will fail to adapt to the changing environment, but will develop as a result of inborn processes of maturation, out of touch

with the environment and badly co-ordinated with the child's own previous developmental pattern. Examples of this primitive psychosis, sometimes termed *anomalous idiocy*, will be quoted below.

3. *Extreme degrees of activity or inactivity* may presage disorders that may last throughout life and which have the characteristic in common of permeating every aspect of the individual's being. An extreme, either of activity or inactivity, may impair or cripple the baby's developing emotional relationships on account of feeding difficulties and consequent frustration of the child's instinctual drives. The children, in frustration, may turn outwards into difficult, demanding, insatiable activity; or turn inwards into a state of withdrawal that, in the case of the previously over-active child, may be impossible to penetrate. Either type of behaviour may have a disastrous effect on the mother's capacity to provide for the needs of her young baby and to bring about the normal modifications of the infant's primitive instinctual patterns.

It is impossible to gauge the extent of a disorder within the first 3 months unless there exist gross somatic manifestations. Except in the case of simple amentia, the later developmental experiences of the child, perhaps more than the original failure, will affect the outcome; and these other conditions will be described in relation to later periods of life. In the case of simple amentia, the outcome depends more on the deficiency than the environment.

SIMPLE AMENTIA

Maurice B. (6) 5½ years

Maurice was the youngest of three children, aged 14, 11 and 5½ years. His mother before her marriage had worked as a typist, his father was a cost accountant. There was no suggestion of hereditary difficulty, and the two older children were of normal mentality.

This 29-year-old mother's health during pregnancy was good, but labour was prolonged, the waters having broken seven days before birth. Maurice weighed 9 lb. and measured 23 in. long, but showed no signs of damage or distress. He took food well from the breast and gained weight steadily. Until about 2 years of age he cried excessively by day and night. Even at 5 he still tended to cry if not warm and well fed.

Teething was up to schedule, but he sat up at 18 months, with a wobbly head. Weaning was slow and tedious; he refused a cup and solid food until about 2 years. At 5½ he would walk only if mother supported him and took some of his weight. Toilet training—at 5½ he had little idea of cleanliness, though he would use a pot if not fussed. Hearing and vision appeared to be normal. Talking—no speech.

His attainments were few at 5½ years, for example, when his mother said, 'Where is the golliwog?', he looked in the right direction. He responded to a happy or a scolding tone in his mother's voice and recognized his father and siblings. He showed preference for certain foods, but could not feed himself.

At 5½ years, Maurice was heavily built. He took no notice of the examiner and

little of his parents. He sat unsupported, sucking his fingers and occasionally shouted loudly. He moved slowly by combined wriggling and crawling motion. He took his weight standing, if supported and pulled himself to his feet, unaided.

There were no physical signs other than poor limb development. His general level of capacity was that of a child of about 9-12 months.

Comment

Maurice's mental development was retarded, with no exceptions. In five years he had, in every respect save that of skeletal growth, shown less than one year's progress. At 7½ years he was able to walk, if supported, perhaps as much as 50 yards. Perhaps he might learn to walk by himself by the age of 8 and talk a few words by 10. He presented no behavioural difficulties other than those inherent in retardation. He represented a typical case of simple amentia of low grade, and without special physical deformity.

April P. (7) 4 years.

April was the second of three children of 7, 4 and 2½ years respectively. Her father had died 18 months previously and the family was wretchedly poor, living in one room in the house of the maternal grandparents. The two siblings were normal and there was no significant family history.

The mother, then 30 years old, had complained of excessive tiredness during pregnancy. April was born at term, natural labour, without forceps; birth weight 8 lb.; breast fed for 2 months only.

April was always a very sleepy, quiet and 'good' baby; feeding was difficult to establish at first. At 4 months she went to hospital for 8 weeks following a sudden prolonged screaming attack with high temperature and convulsions lasting over 3 days, and subsequently, minor twitchings at the rate of about 40 per day. EEG showed no abnormality, but the mother said that she was told that 'due to a clot of blood on the brain, April was blind, deaf and one lung was useless and she would not live.'

April had no fits after 10½ months. Weaning was not completed before 2 years and at 4 she would feed only from a bottle whenever upset. At 4 years, April had no idea of toilet cleanliness; practically none of movement, of feeding herself, nor of communication. She was of normal size, with small legs. Bodily development was markedly dysplastic, with the left side of her body less developed than the right. The very acute angle to her left costal margin might have been a relic of the old left-sided collapse of the lung.

She sat upright on her mother's knee, rocking herself. She sang tunelessly, ground her teeth and vaguely resisted being undressed. She showed little sense of balance and would have rocked herself off her mother's knee if unguarded. She did not attempt to stand, but with support took the weight of her body for a few seconds. The primitive walking reflex had persisted.

Her mother stated that she was not developing, and scarcely moved except for turning over while lying. She tended to sleep by day and be awake by night. April showed slight recognition of her mother.

In addition to general dysplasia, she had internal strabismus, no binocular vision, but could hear sounds. Her legs showed some adductor spasm and right talipes

equinovarus. Tendon jerks were brisker than average, and plantar responses doubtful. Muscular tone was not increased.

Comment

April was a profoundly defective child, indicated by the completeness of her retardation in all aspects of development and by her extreme slowness of development. The widespread bodily defect was confirmatory evidence.

The normality of her birth suggested that the origin of the condition was a simple, primary (congenital) defect. Was the illness at 4 months an encephalitis? In the absence of serological evidence it is more probable that the screaming, convulsions and high temperature were due to neurological instability.

Normally at the age of 4 months, the higher centres of the brain are beginning to function—the complex sensory function of perception and the twin motor functions of innervation of voluntary movement and inhibition of lower brain impulses. In the case of a defective child, poor perception, irregular innervation and incomplete inhibition commonly result in anomalies of function including motor convulsions.

At 4 years April had achieved the development, roughly, of a child of, say, 6 months. By 16 years she might, conceivably, achieve a development to that of a child of 2 years, but current indications were that she was more likely to remain at the most profound level of subnormality.

Christopher D. (8) 6½ years

Chris was the only child of prosperous working-class parents, with no history of familial instability. His mother had been 25 years old during her pregnancy (normal); birth at term, after an uncomplicated labour. Birth weight 4 lb. 7 oz. He sucked ineffectually at the breast for 4 months, gaining weight very slowly.

He was always restless, particularly so at night. He accepted weaning to a cup and spoon passively, and never learnt to feed himself. He sat up at 12 months; walked by himself at 30 months; had never talked; was not fully toilet trained until about 6 years of age and could not dress himself.

At about 4 weeks he had a single convulsion, and a second some months later.

He was very destructive and used to bite holes in his clothes. At about 6 years he learnt to climb upstairs, but not down. In other respects he did not realize danger, though he cried when hurt.

Chris was very undersized, with a small, nearly microcephalic head. He moved stiffly and clumsily with a broad-based and ataxic gait. There was no sign of a neurological lesion.

Chris was mildly interested in toys and handled them desultorily. He was friendly and dependent in manner. He made a few sounds and responded to some cue words and gestures of his mother such as 'show the Doctor . . .'. His mother was a warm-hearted, placid person, who had evidently established an unusually good relationship with one so dull.

Comment

His extreme all round retardation of development was combined with marked physical inferiority. In 7 years Chris had attained a level of, say, 18 months. With his

steady but slow rate of growth an ultimate level of mental development of about 3 years might be hoped for.

Penelope M. (9) 3.3 years

Penny had a step-brother of 8. The family were comfortably situated and with no history of abnormality.

Her mother was 27 when Penny was born; she had suffered from pyelitis during pregnancy, and was unhappy with her husband. Labour was prolonged and the baby rather distressed and anoxic at birth. Birth weight 6 lb. 1 oz. Penny recovered quickly, took the breast well for 7 weeks and transferred easily to dried milk. Weaning to solid foods was easy.

Penny was a very contented baby, 'we hardly knew we had her'. Except for teething, all her developmental landmarks were retarded. She sat up at 10 months; crawled at 12 months; walked alone at 23 months; dry and clean by day at 36 months, but still wet at night and no sign of speech at 39 months. She did not babble much. She could undress and fold her clothes but not help dress herself. Sleeping was undisturbed.

Examination

Penny had a curious facial appearance with mild prognathia and slight microcephaly (circumference $17\frac{1}{2}$ in.). Her motor system was normal and her movements competent. She was active and distractable, but made no real use of the toys. She kept grinning for no apparent reason, or at the sight of her reflection in the mirror. She missed her mother and went to look for her, but otherwise paid little attention to her. She knew the use of common objects like teapots, but had no concept of dolls or other anthropomorphic toys. Her mother described her as happy, but a creature of habit and routine.

Psychological examination (Merrill Palmer Scale) was unsuccessful, since Penny did not understand the situation. It was impossible to hold her attention. She conveyed several of her wishes by gesture. Her motor skills exceeded her level of comprehension. Her mental age was in the region of 15 months.

Upon re-examination at 4.2 years, Penny had grown considerably, developed mentally slightly, but the problem was unchanged. Her vocabulary did not exceed 20 words and her understanding was equally limited. With her increase in size and greater motor capacity, her distractability and overactivity were proving difficult at home. Most of the Griffiths's scale was completed at 4.9 years, and her mental age was under 2 years. She was active and gay, with remarkably fleeting attention. Spoken speech was still virtually absent, but she understood a few spoken requests.

Comment

Penny, like Maurice, April and Christopher, was backward in every respect save that of the first dentition. She also had mild microcephaly. She was reasonably typical of simple amentia of serious degree, with a ceiling of development in adult life of, perhaps, 6 years. The combination of liveliness, relatively good motor capacity, distractability and poverty of comprehension tends to result in too much

being expected of a child. Parents find it most difficult to believe that a child who appears bright and to 'understand absolutely everything you say to her', is quite ineducable and fitted only for an occupation centre.

The diagnosis of amentia depends upon a review of the total mental and physical development of the child. The objective techniques of normal child observation worked out by Arnold Gesell and, for infants, by Ruth Griffiths are not standardized for use in cases of severe retardation, in the assessment of which a 'long section' of development must be taken by repeated observation over a period of some years.

A thorough physical examination is essential in order to compare the child's bodily development with the normal, and to plot the extent of any neurological damage. The diagnosis of amentia can be made confidently within the first 3 months only in the case of gross deformity.

The history of the mother's pregnancy will help very little. The effects of maternal rubella are not at first apparent in the baby. Toxæmia of pregnancy and placental disease may be associated with foetal brain damage and with parturition difficulties and foetal anoxia, but not always. Mental deficiency in either parent greatly increases the chances of mental deficiency in the offspring, but usually of a degree not diagnosable in the early months. Active syphilis in either parent is now a rarity.

Mental deficiency is associated with parturition difficulties, prematurity or postmaturity, delayed, prolonged, or precipitate labour. Unfortunately for the purposes of diagnosis these difficulties can also, even if less commonly, attend the birth of genius.

Severe foetal distress, anoxia and shock and especially white asphyxia are important danger signals, and it is rash to be dogmatic about a baby's normality in these cases. The size of the baby is no guide, though defective babies tend to be small and commonly prove difficult to feed because of retardation of neurological reflex development. They are slow to adapt to everything, feeding rhythms, night and day, bathing and playing, but it is difficult to be certain about these matters within 3 months of birth. A minority of mentally defective babies are over-active, restless and noisy, but trying combination when it exists together with a lack of adaptability; but far more commonly they lack instinctual energy, are lethargic, and do not thrive.

The early diagnosis of paresis due to brain damage is equally difficult. Shock is an important danger signal, but is not invariably present. The location rather than the extent of the damage will determine the outcome. When the infant has fully recovered from any shock at birth it may be observed that the baby's uncoordinated movements are asymmetrical or partially absent. Only gross damage will show up before the third month, after which time motor disabilities may become apparent as voluntary movements develop.

Spastic weakness and rigidity will develop along with myelination of the cerebrospinal tract.

Mongolism is usually recognizable at birth, provided any moulding present has disappeared. Mongolism is one of several medical conditions that should never be diagnosed unless there is no doubt whatsoever in the mind of the examiner. There is no such thing as 'a slight touch of mongolism'. Many backward children present a certain ruggedness of appearance which may mislead the observer into thinking of them as 'mongoloid'. There must be present a representative sample of the characteristic stigmata of mongolism before the diagnosis can be made (see Chapter 4).

Cretinism is occasionally so obvious that no mistake can be made and in this case vigorous treatment must be instituted on mere suspicion. Delay is extremely harmful in this condition.

Apart from these special instances, the diagnosis of amentia is a matter of waiting for evidence in order to assess the child's rate of development, over a period of not less than 2 years. If, in addition to severe mental retardation, there is clear evidence of physical inferiority, and if the retardation is consistent and apparent in all aspects of the child's development, there is strong presumptive evidence of amentia. If, after 2 years' observation, it is possible to establish that the rate of the child's development in all its aspects is bearing a constant ratio to the normal, future development can be foretold with some confidence. Observations must be made methodically and in detail, but developmental scales must be used only in combination with a full clinical examination and assessment of the social environment. A final verdict should not be given before there has been 2 years' observation.

Chapter 7

The Foundation of Interpersonal Relationships

DURING the first 12 weeks of life the main activities of the baby lie in the directions of establishing life, of growth, and of setting up a two way contact with the immediate environment.

We have now to consider the role of Instinct in this establishment of contact, but since a book on clinical phenomena is not the correct place for a theoretical discussion we shall limit ourselves to a general statement of the theory on which the clinical classification used in this volume is built up.

There has been general agreement among psychologists to regard an instinct as an innate trend or tendency carried in the genes. Its origin owes nothing to the environment, but its direction and goal may be greatly modified by circumstances.

An instinct, as defined here, has an origin, a direction, a quantum of force or psychic energy, and an objective. Though inborn and starting from within, it necessarily becomes involved in the environment unless, as may happen in disordered development, it turns inward to seek a goal within the individual. The achievement of a goal by an instinct is accompanied by a fall in emotional tension, a sense of satisfaction and of pleasure. The frustration of an instinct is accompanied by a rise in emotional tension, dissatisfaction and pain.

There have been very many attempts to classify and describe instincts. Using a structural approach, McDougall described 17 instincts, each subserving a distinguishable role. A dynamic theory of psychology, on the other hand, does not postulate separable instinctual trends, but, rather, regards instinct as a moving force capable of becoming canalized into various directions, concurrently.

PSYCHOANALYSIS AND INSTINCT THEORY

Freud's dynamic approach made a great contribution towards the unification of instinct theory. Historically, psychoanalysis has evolved around the concept of primary life forces in the direction of life, of reproduction, and to a less extent, of death. The question which is the primary, the most fundamental or the strongest of these drives, has exercised thinkers for many years. The importance of establishing, as it were, a hierarchy of drives becomes apparent when considering aggressivity—the force or energy that serves the instinct—for it will be of some significance to know whether aggressivity is

primarily in the service of self, or of reproduction or even, conceivably, of death.

After considerable change of view, Freud came to emphasize the importance of reproduction. Psychoanalytical studies of the sex instinct have long been basic resource material in psychology. Freud's delineation of the sexual development of the child as a continuous evolution from earliest infancy, opened a new epoch in psychological thought. But it is to be wondered whether a certain rigidity in later psychoanalytical thinking has not tended to obscure its own discovery that instinct is a vital, dynamic process. In what follows, the author does not adhere strictly to orthodox psychoanalytical theory, but would wish to acknowledge his great indebtedness to the uniquely important discoveries of psychoanalysis, which everywhere permeate the concepts used in this present volume.

SOCIAL INSTINCT

It is generally agreed that among animals, instinctual activities go in two main directions, self and reproduction, but more than 40 years ago, Wilfred Trotter wrote of the 'herd instinct' in Man; and in the formulation of McDougall, group or herd instincts are prominent. Recently ethologists have refocused interest on the possibility of the existence of a primary social instinct in the human baby.

Animal ethologists have described, in herd animals, the existence of certain innate tendencies that lead to the formation of social relationships and to the inhibition of antisocial drives. The former can be seen in the reflex following shown by the greylag gosling and in the many 'calling-out' reflexes of birds; and the latter in the orders of precedence and the control of sexual activity found among many herd mammals, and in the form of inhibition in Lorenz's¹ dramatic description of two male wolves fighting but coming to no harm. Because the term 'herd' implies a herbivorous and ruminant social structure, for Man the term 'horde' is perhaps preferable.

INTERPLAY OF INSTINCTUAL FORCES

The continued existence of the human race would be inconceivable without its young having an innate power to build up and maintain the self. Freud regarded this life instinct as a derivative of the main stream of instinct that was tending towards reproduction. Clearly no reproduction would be possible without life. Perhaps it is not important to attempt to award a predominance to any one direction that instinct may take. Embryology has shown that, in somatic development, different aspects of development will be predominant at different times in the life of the foetus and young child. It may be that the same is true of instinct and its various trends of development.

In postulating that sexual development—a manifestation of the reproduc-

¹ Lorenz, Conrad: *King Solomon's Ring*, 1952. London: Methuen.

tive instinct—is a continuous process from birth, Freud demonstrated that much of the child's behaviour in connection with the establishment and building up of life is also in the service of the sex instinct. The baby has only a limited range of organs to serve instinctual drives, so that it is unprofitable to attempt any rigid system of discrimination between directions of instinctual behaviour. For example, the penis is used in common for the ego-centred instinctual process of micturition in the service of self maintenance, and for reproduction; and behaviour in relation to the penis may have either significance at different times.

Psychoanalysis has traced the emergence and differentiation of erotism by way of the mouth, the anus and the genital area, and has described the establishment of a pattern of sexual behaviour and satisfaction. Freud drew attention to the sexual significance of the baby's sucking and of the baby's relationship with its mother, even though direct sexual behaviour may not be shown by that child within 15 or 20 years. However, it could not be claimed that the baby's oral and anal activities are exclusively in the service of reproduction, nor is this true of the organs used later in genital activities.

In sexual pleasure, nature, as it were, is at some pains to make sexual activity worth while to the individual; but the instinctual force in the case of feeding and excretion is so strong that these latter are unavoidable. The building up and maintenance of life has an earlier and stronger claim than reproduction, upon the organs that subserve both purposes.

There is a third possible main direction of instinct—that of a social instinct. The new-born baby is quite asocial as well as sexually undifferentiated, but this does not imply that social, any more than sexual, development is not innate nor not present from birth. Since the oral satisfactions of the baby serve both ego-centred and sexual ends, there seems no *a priori* reason why they may not also have a social objective. The relationship that a child builds with his mother is a biological necessity for survival and development. It also establishes a pathway towards the formation of future sexual relationships. May it not also establish a pathway towards social relationships?

INSTINCT AND CHILD DEVELOPMENT

The child will take three main directions of development which overlap; first, to become an individual; secondly, to enter into social relationships; and thirdly, to enter into sexual relationships.

Each of these developments involves something or somebody in the environment; they are also interdependent. No child can progress in the second and third without having completed the first; and Man, in common with herd animals, cannot complete the third without some success in the second.

The human child has three sets of equipment for these tasks: inborn sensory and motor systems; innate instinctual drives and their attendant somatic functions; and his mother, or the person normally caring for him.

The first step towards individuation is taken with the formation of the *ego* which, in psychoanalytic terminology, is that part of the personality which is formed by the interaction of instinctual drives with the environment. The mother performs ego functions for the new-born child, permitting him to react only to those environmental influences that come within the child's competence, protecting him from excessive or inappropriate pressure, until the child's ego is sufficiently developed to do these things itself.

The primitive innate reflexes appear to serve primarily ego-building functions, e.g. crying and sucking reflexes; or ego-preserving functions, e.g. light avoidance, light fixation, startle, walking and plunging reflexes, which appear to be archaic survivals of ego-protecting reflexes of greater importance to the higher mammals.

We have referred above to the baby's capacity to achieve some slight degree of orientation in time, viz. to feeding rhythms and to night and day. It is not outwith the bounds of possibility that this unexplained infantile capacity represents the first outward manifestation of social instinct; following upon which comes the reflex smile of the baby to the human mask; and then the social smile; followed by the baby's differentiation between the mother and other people. Concurrently there appears the dawn of consciousness and of self-awareness; and the emergence of pleasure and pain in connection with instinctual drives.

THE PAIN-PLEASURE CYCLE

The primitive pain-pleasure cycle of babyhood has survival value and thus contributes to ego-centred instinct; psychoanalysis has described its sexual significance also, in establishing a pattern of instinct object seeking and instinct satisfaction, and which promotes the development of affect. Similarly the pain-pleasure cycle may have a social significance in the attachment of affect to the first instinct object, the mother. (Throughout what follows 'he' will signify the baby and 'she' the mother, but, unless the context clearly contra-indicates this, the case of female as well as that of male babies will be equally implied.)

At 10 weeks, or shortly after, the baby will follow his mother with his eyes, and his reflex smile will be replaced by his 'social smile' of recognition which becomes specific to his mother (or whoever normally feeds and cares for him). With this degree of specificity of reaction, it is clear that the baby is beginning to differentiate between the objects in his environment. Before long, he will arrive at some perception of self, however primitive, as distinct from his surroundings. This happens before 6 months, as may be judged from the 6 months' baby's reaction as a single unit, purposefully and distinctively and with memory, to a wide range of environmental stimuli.

Self awareness develops at a time when the child is having the impressive experience of being fed about 5 times every 24 hours, a procedure that may

occupy half of his waking life. Moreover, as noted in Chapter 6, the innervation of the alimentary canal which is the only highly organized part of the baby's sensory system is his only route of sensory learning, except for a certain crude responsiveness to skin stimulation and muscle sense.

It has been noted that experience of feeding is very striking. Adults know that hunger causes discomfort, even pain; that eating gives pleasure to the hungry; and that to have fed well is profoundly satisfying. It is not known for certain when the baby becomes conscious of these experiences, but it would be rash to assert that a 6-month-old child, for example, had no subjective sense of discomfort when hungry, pleasure when feeding, and satisfaction when filled. By 6 months, at least the child has gained a primitive awareness of self as distinct from environment; of a specific influence in the environment (his mother); and of uncomfortable and pleasurable sensations associated with feeding (and with his mother).

Five times every day his mother cures for him the only pain he experiences, and gives him instead his only vivid pleasure and his only real satisfaction. This is the primitive pain-pleasure cycle of babyhood, which establishes that vitally important characteristic of higher animals, as well as of human beings, of associating instinct frustration with pain, and instinct fulfilment with pleasure-satisfaction.

THE FORMATION OF OBJECT RELATIONSHIPS

Hunger pain and feeding pleasure are extremely important to the ego-building instinct, for the maintenance of life depends upon them. We have now to consider the possibility that as the baby becomes capable of perceiving objects in the environment, pain-pleasure feelings will become attached to these perceived objects, which will be the beginning of *object relationship* formation.

It is often claimed that the first object relationship of the baby is with his mother's breast, that the unsatisfied baby may see the cause of his troubles as the depriving or even avenging breast. It is worth while reviewing in greater detail the state of the baby's perceptual system.

Skin Sensation. Under 3 months of age a hungry baby can be pacified only by feeding, though he may be calmed for a few minutes by picking up, cuddling and stroking. There are, therefore, two main perceptual routes: through the lips, mouth and stomach; and through skin and proprioceptive sensation. Observation reveals that for the first 5 months of life the mouth is the baby's main instrument for exploration of space and the qualities of matter, but that in the mouth, taste, pain and temperature sensation are crude and minimal. The alimentary canal responds sensorily only to tension. The baby's skin sensation is also crude and poorly discriminating in respect of pain, temperature and touch, but more responsive to gentle pressure and stroking; and proprioceptive sensation is responsive to passive movement. The hands, later

the most highly discriminating sensory instruments of touch and space perception, appear to be inferior to the mouth for these purposes until after the fifth or sixth month.

It is likely, therefore, that the child's first percept of the mother is as a nipple in the mouth and a stomach distending agency; and his mouth and stomach pleasures and pains arising from ego-centred instinctual happenings will increase as he grows older. In addition the mother may be perceived, though dimly, as a stroking, cuddling and body-moving agency. It is reasonably certain that before vision becomes functionally established the baby's sensory apparatus cannot discriminate an object with the consistency and shape of the human breast. There is, in fact, a possibility that the breast may make an affectively negative impression on the new-born baby—by occlusion of nasal breathing during suckling which would be an anti-instinctual, potentially ego-destroying hazard that will be discussed further in Chapters 8 and 9, in connection with feeding difficulties and infantile asthma. *Vision.* The observations made by Spitz suggest that the emergence of functional vision does not at first enhance the importance of the breast percept, but rather that the first visual percept of the baby is his mother's face in movement. He is too close to the breast to allow of the formation of a purely visual percept of the breast until at about 5 months a more effective instrument of environmental exploration develops in the form of manual sensation combined with vision. The older child can be observed while suckling, feeling the breast, retracting his head and looking at it, forming first a percept and then a concept of the breast, just as he forms percepts and then concepts of all environmental objects and occurrences.

By 5 or 6 months, the baby has already formed a stable percept of the mother as a moving whole; as shown by his giving a feeding response to her fully clothed presence. It must be concluded that the great pain-pleasure learning experience of feeding, with the powerful affective system that is aroused, is established primarily with the whole mother, though the child's concept of this wholeness will be incomplete for a long time. Otherwise, a great difference would be observable between breast- and bottle-fed babies, a difference which is conspicuous by its absence.

It would be fallacious to deny, from this, the psychological importance of the breast. All folklore, legend, poetic speech; the history of erotic practices; pictorial art; the cinema; advertisements in glossy magazines and on posters, testify to the importance of the breast to humanity. But the affect attached to the breast is, perhaps, not quite basic to the child-mother relationship. Earliest comes mouth, stomach and skin sensation, then the visual concept of the whole mother and only third, the breast.

PAIN-PLEASURE IN THE SERVICE OF THE BABY'S INSTINCTS

Pain-pleasure in the feeding cycle is a manifestation of the ego-building

instinct, by which psychic energy becomes invested in the pursuit of food. But getting food is not the highest end of Man and will be a dominant issue only in the case of serious insufficiency. The importance to development of pain-pleasure in feeding is that of setting the style of instinctual drive and its concomitant affect. At the age of about 3 months, this pain-pleasure situation begins to pass into the service of the social instinct or, as some prefer, the sex instinct. Whichever way it is, the baby's relationship with the mother becomes invested with instinctual pain and pleasure. This is a tremendous stride forward in development, for the baby is no longer entirely egocentric.

There is a need for much greater knowledge of the respective roles of social and sex instincts in very young human babies. It is easy to trace distinctive differences between social and sexual behaviour among solitary and gregarious animals and birds. All animals show distinctive mating behaviour and develop mating relationships, which among solitary animals not uncommonly last for life. Herd animals, in addition show a wide spectrum of socially directed behaviour, including social relationships with a non-sexual aim, and inhibitory mechanisms that control aggression and antisocial behaviour.

A PRIMARY SOCIAL INSTINCT

In view of recent evidence about the existence of social instinctive drives, it is no longer possible to regard all social behaviour as displacement or sublimation of sexual drives. The behaviour of psychotic children shows that sexual development can proceed in the absence of social relationships. But in human society, sexual behaviour is so bound up with social pattern that it will not find a normal goal or satisfaction in the total absence of social relationship. Conversely and more impressively, it is a commonplace for an individual to have adequate social relationships but weak or absent sexual drives.

We may recapitulate and conclude that, whether the main instinct activities of this period be primarily ego-building, social, or sexual; or all three in various combinations; the importance of the developing child-mother relationship cannot be rated too highly. The strong feelings aroused in the child by the repetitive experience of being fed become attached not only to the feeding process, but also to the person who is providing the experience. The child perceives his surrounding environment as a pain-curing, pleasure bringing, feeding and comforting, instinct satisfying agency, as a result of which he makes not only his first object percept, but also his first positive affective relationship with an external object—his mother.

Satisfaction of the baby's primitive ego-building instinctual drives will leave his social instinctual drives free for deployment. He will begin to move away from egocentredness from the time that his feeding satisfaction begins to be displaced on to mother relationship satisfaction.

FURTHER OBJECT RELATIONSHIP FORMATION

Two important somatic developments: binocular, directed vision; and use of the hands, successively through palmar grip, thenar grip and digital manipulation enable an enlargement to take place in the baby's object percept system. His first discovery will probably be finger sucking, which will open up to him the auto-erotic possibilities of the body and the possibility of the transference or displacement of instinctual satisfaction and pleasure. The child gains not only oral sensation from finger sucking but also begins to distinguish his fingers from other percepts. At around 3 months of age babies spend much time lying in their cots, sucking their fingers, looking at them, then sucking again. Shortly after 3 months they first begin to use the hand as a tool, the hand having been accepted as part of the body percept. Objects are now conveyed by hand to the main sensory organ (the mouth) for exploration and, in addition, vision and touch begin to be harnessed to the learning process. From percepts in shape and texture the baby goes on to make percepts in limited space and movement, and within 2 to 3 months the child becomes master of the area of space within arms' reach. However, for some months he will continue oblivious of objects and happenings outside this range, except for awareness of his mother and other very special adults.

The baby enters into this world entirely on the strength of the maternal relationship. He must make the first rudimentary turn outward to his mother and must displace some of his feeding satisfaction outwards on to primitive object relationships before he can form other external object relations. Failure to do this will be illustrated in the cases of primitive psychotic children described later in this chapter. The mother's ego-building role for her child is to select environmental influences to play upon him; to exclude some, admit others and to watch over him, helping him to gain satisfaction and protecting him from frustration too great for him to bear.

Social instinct provides that the outward turning baby will displace some of his feeding satisfaction to the acquisition of skill and attainment, the value of which are greatly enhanced by his positive maternal relationship which will help him to bear his frustrations and compensate him. Thus he will gain the impetus to persevere in the learning of new things, and he will receive help to control his feelings when in difficulty and frustration.

The significance of this developmental period is very great for, having established the style of his object relationship formation, the baby will go on to a greater range of object perception and to form wider and deeper relationships. When his style of object relationships is healthy he welcomes new experience, is curious about his surroundings, and meets new things in a spirit of confidence. He will respond to experiences introduced by his mother with particular readiness, and the maternal relationship will remain his most

important route of learning, though in diminishing degree, throughout the pre-school period.

One very important babyhood lesson is adjustment to changes and alterations in rhythms of life. The wise mother will introduce the baby to variety, in small doses, as it were, and support him during the adaptations that he makes. Life lived spontaneously in the normal household should provide sufficient experience of variety; it is the rigid baby care schedule that can do the greatest harm in this respect.

INTERRUPTION OF THE BABY-MOTHER RELATIONSHIP

In recent years, much attention has been given to the effects of separation of the baby from the mother. At a time before a strong and durable relationship has been formed, the effect of separation will depend mainly on how the separation actually impinges on the child, i.e. the difference in care and in rhythms of life that separation may cause. The good nurse or foster mother will take the trouble to find out what has been going on previously, and may be able to reproduce the original style of maternal care so closely that the limited perceptive capacity of the baby will not distinguish the difference sharply, perhaps up to the age of about 6 months. Many of the baby's adverse reactions to change of care are due to a switch from breast- to bottle-feeding; and when the bottle is wielded by a stranger not emotionally involved in the process, the quality of the change may exceed the baby's powers of adaptation.

At this age babies show immediate somatic signs of disturbance, notably feeding and sleeping difficulties. The baby loses appetite, suffers from diarrhoea and/or vomiting, and commonly has bouts of high temperature. Loss of weight is inevitable if feeding is interrupted, and dehydration will be a serious and immediate danger. The sleep disturbances probably reflect the general upset of body rhythms. The baby in this state is prone to intercurrent respiratory infection, and serious illness or even death from bronchopneumonia is common. There is here a potentially dangerous combination of circumstances; that interruption of maternal care will lead to somatic illness in the baby, and thus to hospitalization which will increase the degree of separation of mother and child.

The long-term effects of interruption of maternal care during the first 6 months are serious when satisfactory substitute relationships are not formed. Children in trouble regress; but when, as in the case of a young baby, there has been little development to lose, stagnation can result in a failure to form object relationships.

FAILURE TO FORM OBJECT RELATIONSHIPS

On theoretical grounds, weakness of social instinct is the most likely cause of failure of the baby to form a relationship with anybody or anything outside his own body; but in practice, when this happens, abnormal environmental

circumstances will probably also be present. The cardinal feature of such failure is that feeding pleasure remains limited to oral and alimentary satisfaction, with a slight skin and proprioceptive element. The baby fails to particularize and discriminate the mother and fails to displace any of his feeding affect from feeding satisfaction on to his mother. He fails also to perceive other objects in his environment and, in general, the outside world means nothing to him.

It follows that he will be unresponsive to visual and auditory stimuli, and often the adults in charge believe him to be blind and deaf. He remains recumbent, continuing to move his limbs in an archaic way. He is not likely to have disturbances of feeding or sleeping and will fit easily into regular rhythms of living which, once established, have a quite abnormal durability. These babies usually take the breast or bottle well, have no hunger disturbances, are quiet and contented between feeds, and often sleep 12 hours at night. Parents will often say: 'He was so good and contented that sometimes neighbours would ask us what had become of him', or, 'I used sometimes to go and peep at him to reassure myself that he was still alive'.

Unfortunately it is likely that the natural reluctance of parents to disturb an apparently contented child will contribute to the failure to form relationships that the child of weak social instinct may suffer.

It appears to be an integral part of the condition under discussion that the mother-child relationship is either grossly or subtly deficient. Often it is difficult or impossible to discern when the trouble started. In some cases the child appears to have been blandly unresponsive to all environmental stimuli other than regular feeding, in spite of all that a good mother could do. In other cases the mother has been at fault, however unwittingly, for she has failed to 'get across' to the child; e.g. psychological rejection of the maternal role by the mother can lead to perfunctory feeding; no talking and playing during feeding and bathing; and absence of skin contact and caressing. Perhaps an impersonal feeding machine may get only an automatic response. The tense or anxious mother may think only of what she can do to keep the baby quiet, and she will not recognize and thus ignore all the little signals that he may be making. It is remarkable that mothers of autistic children seem often to be extremely tense and anxious, though admittedly their anxiety may derive in part from the enormous strain of living with an autistic child.

Most commonly, failure to form object relationships arises out of a combination of these various elements. The baby is weak in social instinctual drives and the mother may be weak, too, in her maternal response. The very 'easiness' of the baby is a pitfall for the mother who is ignorant of baby needs, or unhappy in her maternity, or preoccupied with family difficulty. She is thankful for her baby's docility and knows no better than to leave him alone. She fails to pick up the weak signals he is giving out; and she, herself, gives

only weak signals in return. The nett result is that the baby's out-turning, object-seeking impulses fail to find their object: the differentiation of the mother figure. Therefore feeding pain-pleasure will remain centred in feeding, and the baby's developing social drives will find objects only in his own body. The mother will then discover that the baby is impenetrably unresponsive, and the whole family development pattern will be thrown into chaos; for the family, as well as the baby, develops its style of living as they all grow older together.

VARIATIONS IN DEGREE OF OBJECT RELATIONSHIP FAILURE

Like most developmental failures, failure to form object relationships is rarely complete. The most nearly absolute level of failure is met with in profound amentia (see Chapter 6), but even in this case total fixation at an early infantile level of development is uncommon.

In the cases which we are now discussing the difficulty tends to be limited to the sphere of object relationships. Somatic growth and neurological development will be essentially normal, except for the adverse effect of lack of formation of normal object relationships and the even more crippling handicap to growth of loss of the normal process of modification of instinct.

Children suffering from failure in object relationship formation will show a patchy and anomalous backwardness that may be difficult to distinguish from the more regular backwardness of amentia. Recognition may be extremely difficult in those cases where later developments and distortions have obscured the original condition.

CLASSIFICATION OF OBJECT RELATIONSHIP FAILURE

In attempting to provide a scheme for classification, based on a hypothetical system of psychopathology and ætiology, we have to consider factors normally taken into account in the study of developmental problems, viz.:

1. *Constitutional*, including innate pattern of growth and maturation;
2. *Environmental*, and, in particular, the phase in the life history in which environmental factors are active;
3. *The Resultant* of constitutional and environmental factors, as seen in tendencies towards integration, compensation, or disintegration.

I. CONSTITUTIONAL FACTORS

In Chapter I two bimodal scales of constitutional variation of *quantity* and *quality* of human behaviour have been postulated:

- (a) The hyper-active/hypo-active scale.
- (b) The out-turning/in-turning scale.

The effects of hyper- or hypo-activity can be traced in the intensity with which behaviour patterns are pursued by the child, whether in restless movement or in absorption in inner psychic life. Because of their greatly restricted

field of activity, children who are failing in object relationship formation often show behaviour so abnormal as to give a misleading impression of the amount of activity present. For example, an autistic child entirely given over to a single repetitive action may give an impression of hyper-activity when the total amount of activity is, in reality, very small.

Variations in the out-turning/in-turning scale may be equally misleading. This aspect of the subject is difficult and obscure. Primitive object relationship formation is both an out-turning and an in-turning process. The differentiation of an external object implies the differentiation of self; and formation of identity implies the identification of the environment as well as the self.

The extreme in-turning baby will give out only weak signals, as it were, into the environment; and will be in some danger of not forming relationships should the mother not be compensatingly strong in her approach to the baby. There are many possible causes of weak maternal approach—e.g. her own extreme in-turning temperament, her negligence, rejection, or absence through illness or other cause. Less obvious causes may be equally damaging, e.g. the very tense and nervous mother who cannot handle her baby comfortably; who is not sufficiently receptive to listen to or look at her baby, and is therefore insensitive to his needs; or the mother who is only too thankful that her baby is quiet and who leaves him alone all his waking hours, except for a minimum of feeding and washing. So treated, an in-turning baby may fail to particularize the external environment and remain weak in perception and conception of self. His activities will continue to be ego-centred and he will remain preoccupied with parts of his own body, which he will not recognize as such.

The extreme out-turning baby, on the other hand, will give out much more vigorous signals, pre-eminently restlessness, which may make him difficult to feed. He does not settle down to steady, efficient sucking and this may undermine his mother's confidence in her handling of him. Continuous restlessness will mean increased metabolic needs and greater likelihood of unsatisfied hunger. Restlessness and hunger together mean diminution of sleep and will lead towards chaos in the home. The unsatisfied baby will lack primitive feeding satisfaction to transfer to his relationship with his mother. Thus the extreme out-turning baby, also, may fail to particularize both his mother and his own self and his restlessness will continue unabated in his uncomprehending exploration of his own body. By the seventh or eighth month, as maturation proceeds, the baby's major activity will shift to insatiable exploration of the surrounding environment; insatiable, because he will fail to relate what he finds either to himself or to his mother and will therefore fail to reach even primitive concept formation. It is remarkable to watch such a child discover and rediscover his own big toe, several times during the course of a few minutes, look at it intently, feel it with his hands,

and put it in his mouth. Then the impulse will die out, only to reappear shortly after.

2. ENVIRONMENTAL FACTORS

As previously stated, the common harmful environmental factors present at this stage of life comprise the various forms of maternal neglect, whether caused wittingly or unwittingly, or the result of inescapable circumstances. Perhaps the most important will be any failure by the mother to satisfy the child's feeding needs promptly and completely; but the mother's failure to talk to and make a fuss of the baby may also be a serious drawback.

The mother, like the child, may be in-turning or out-turning by nature and, if at either extreme may give out weak or strong signals, respectively, which, in the early weeks, may strongly affect the outcome. In the earliest phases of relationship formation, intensity of communication counts for a great deal.

Failure of environmental influences after some relationship has already been established will result in a different range of phenomena, complicated by both the child's and the mother's reaction to the then existing situation. The clinical effects of this will be illustrated later, in Chapter 8.

3. THE RESULTANT

The resultant of constitutional and environmental factors can be seen, phenomenologically, in three trends, respectively in the direction of integration, compensation, and disintegration.

It has been noted above that only rarely will there be a complete failure in relationship formation; but the commoner outcome of an impairment of mother-child relationships may have a very wide range of later effects.

Reactions of integration are essentially healthy. On her part, the mother will make special efforts to enter into a relationship with the baby, and the baby also may show a heightened reactivity characterized by demanding behaviour. There is a danger that strong integrative reactions may go further than correction of an unsatisfactory situation, and may become reactions of compensation in which the aim of both parties may be the attainment of an unusual degree of satisfaction. The chief danger is that compensation may lead to a regressed form of satisfaction being sought by both parties—one more suitable to an earlier phase of babyhood.

Because of the strain induced by compensating behaviour it may be only a short step from a compensating reaction to a disintegrating one and, indeed, some babies' reactions never show an integrating direction. In a disintegrating reaction, the child's behaviour will get more and more out of touch with the values of the environmental situation, and he will show up correspondingly as becoming more and more abnormal.

The evolution of a disintegrating reaction can be foreseen only by reference

to the normal processes of instinct modification and the normal later refinements of the child-mother relationship.

NORMAL PROCESSES OF INSTINCT MODIFICATION

Instinct modification is discussed more fully in Chapters 8 and 9; here it will be useful briefly to review the main features of the process. In the process of weaning on to solid foods, the child adjusts to a minor modification of his instinctual feeding behaviour and in so doing widens his experience, gains an increase in skill, enriches his relationship with his mother and begins to develop a favourable attitude towards new experiences. Later, toilet training will introduce the child to the control of his behaviour by himself, first by means of his relationship with his mother, then on his own responsibility. Later, the child's relationship system widens to include other individuals, and then groups and institutions with which he will identify and incorporate within himself their systems and standards of conduct. Later still, he will begin to appreciate the abstract principles behind environmental happenings and, slowly, his system of conduct will become related to abstractions.

DISTURBANCES OF INSTINCT MODIFICATION

Among the children we are now to consider, early instinct modification has become disturbed, and the clinical picture is composed of the disturbances and the various corrective drives both in the child and in the environment. Typically, the children show nothing unusual at or shortly after birth, or in early feeding and sleeping rhythms. Occasionally but not necessarily, feeding and sleeping habits prove difficult to establish or to change as in the case of Norman R. (10). Usually early infancy is remarkably free from disturbance, except for the child's unresponsiveness to human society after 3 months. Subsequently, the child appears to be preoccupied with his own body—gazing at and sucking his fingers and toes, ignoring toys. He shows no response to his mother's presence and may not gaze at a moving object. He makes no attempt to raise his head from the pillow and when propped up takes no notice. He is passively responsive to body stroking and rocking, a taste which he may retain to an advanced age. He will passively, almost automatically, acquire the skill to sit up, but only after much propping up.

Thereafter the clinical picture will vary according to whether the child is in- or out-turning; active or inactive. In general, each new skill appears late, if at all, and then only in virtue of maturation. For example, an active, out-turning child may crawl late, but continue to crawl long after the normal age of walking, then without warning suddenly walk, with a very short period of staggering gait. Talking will be even more retarded, and appears first as echolalia, then is confined to substantives. Some of these children will go on to use verbs; rarely, adjectives and adverbs; and prepositions almost never.

Their interpersonal relationships are absent or indiscriminating: the in-turning child is withdrawn; the out-turning child is everlastingly pre-occupied with the environment, but he fails to discriminate between animate and inanimate objects. He is poor at judging relationships in space and movement. He will rarely appreciate even the simplest principle.

The full range of this interesting condition is too varied for more than summary mention in this volume—particularly in relation to the obsessional 'filling-in' mechanisms that these children show and the intellectual compensation developed by a very few in later childhood. The reader is referred to the increasing range of literature on this subject.¹

The six cases described below illustrate problems of disorder of primary relationship formation at a very primitive level, before the modification of primitive instincts has become an important issue in the child's development. In Chapter 9, cases (34) to (39) illustrate a primary failure of relationship formation followed by a chaotic disorder of the process of instinct modification and its concomitant emotional development. This latter condition is commonly known as psychosis of childhood.

FAILURE OF PRIMARY RELATIONSHIP FORMATION

Norman R. (10) 7.3 years.

Norman was the only child of a printer's compositor whose wife had been a short-hand typist before marriage. There was no family abnormality, but their life until shortly before Norman's birth had been unhappy through sharing a house with the paternal grandparents. Pregnancy was normal; labour lasted about 48 hours, but was not difficult; birth weight 8 lb. 2 oz.

He sucked the breast poorly for one month, but bottle feeding was scarcely more successful; 4 oz. of milk used to take an hour. When weaned at about 6 months, he refused all milk abruptly, but the feeding difficulty continued. His mother said, 'He just would not swallow.' He fed himself with a cup and spoon at about the age of 4 years, but at the age of 7 years weighed only 42 lb.

Sleeping always caused difficulty, with screaming fits as a baby and disturbed nights up till 4 years. His mother claimed that he first smiled at 2 months. At 7 months a sharp attack of diarrhoea and vomiting upset him.

At 9 months he sat up unsupported, but made no attempt to crawl. 'It took him a long time to gather confidence.' Walking was finally achieved quite suddenly at 36 months; when he also became dry by day after immense trouble taken over toilet training. He was still wet at night.

At 21 months he was in hospital for 7 days for a hernia operation. This experience apparently made no difference to his behaviour. No fits or convulsions.

As a baby he appeared to be responsive to cuddling, but later he took less notice of his parents and 'right up to the age of 4, did not seem to be aware of anybody'.

¹ See *inter alia*, A. F. Tredgold's *Textbook of Mental Deficiency*, (1956) 9th Edition prepared by R. F. Tredgold and K. Soddy. London: Baillière, Tindall and Cox.

Even at 7 he still put objects indiscriminately into his mouth, but showed food likes and dislikes. At 7 years he was just starting to notice other children.

He could recognize his father and some other relatives. Sometimes he was obedient; his mother said: 'sometimes he appears to hear you and sometimes not.' He could dress himself, slowly.

He had curious mannerisms, e.g. patting objects for minutes at a time, or swinging a piece of string around for 'several hours', appearing quite self-absorbed while doing so. His mother said he appreciated classical music and could, she claimed, learn a tune quickly and hum it perfectly.

At the Occupation Centre he was in constant trouble through restlessness, climbing on to window ledges, tables and chairs, making noises and running from end to end of the room.

After the age of 6 he had passed into a quieter and happier phase, and was screaming less.

Examination

Norman gave his hand to the examiner, but his idea of how to descend a steep flight of stairs was to step into space. Apart from this, his movements were deft and well controlled.

He looked like 4, not 7 years old, with very blond hair and an alabaster complexion. His face was quite expressionless like that of some blind children. He sang some half recognizable popular tunes in a nearly tuneful voice.

He was withdrawn and practically inaccessible. He looked up occasionally, but not always when spoken to, and took no notice of what was said. He followed gestures indicating entering and leaving the room.

His play was withdrawn, solitary, perseverating and obscure to the onlooker. He was active, grimaced and sang, with brief crises of shouting and stamping. Otherwise his mood was remote, but serene. He stood for several minutes twirling a piece of string, transferring it from hand to hand.

When sat on the doctor's knee, he relaxed, put his arm round the examiner's neck and kissed him, like one in an hypnotic trance. He rocked himself contentedly in time with the doctor's movement and made no attempt to get down.

Comment

Norman, atypically, had had early feeding and sleeping difficulties, but he was typical in that the rhythms, once established, were very hard to vary. His complete intolerance, for months, of anything solid going into the mouth was particularly noteworthy.

Features distinguishing this case from simple amentia were that the backwardness was patchy, new skills were acquired late but once they appeared, were rapid in development. His primitive body erotism—rocking and response to cuddling—resembled the passive enjoyment of a 3-month-old baby, and lacked any outgoing relationship component. He showed a somewhat paroxysmal or climactic pattern in his internal fantasy life. The gap between his poor capacity for concept formation and his relatively greater motor capacity was filled by obsessional or repetitive ritual acts.

Norman appeared to learn only by simple conditioning to feed himself and con-

duct himself in the routines of living, even to the extent of looking up after each 'paroxysm'. He showed no sign of relationship formation with either his human or material environment.

We have termed Norman's condition *anomalous idiocy*, because his mental faculties were those of an idiot, but certain motor skills were more highly developed. Norman's hand movements in twirling a piece of string were quite beyond the capacity of an ament.

HYPERKINETIC DISORIENTATION

Clare K. (11) 2.9 years

Clare was a twin, with another sister 15 months older. They lived in a council house; father was a milk roundsman, an affectionate man; but mother had been an only child and was undemonstrative with her children. There was no history of mental disorder in the family.

Clare was making no progress, either physically or mentally. She was remote and detached, refused to be picked up and only recently had allowed her mother to nurse her. Previously she would make a fuss only if she happened to be shut out in the garden.

The mother's second pregnancy, at 20 years of age, was normal and twins were not diagnosed until the 8th month. Labour lasted 12 hours, and Clare was born half an hour after Susan. Susan weighed 5 lb. 15 oz., and Clare 4 lb. 11 oz. Susan was breast fed for 6 weeks and Clare for 10 months—she sucked well but gained weight slowly. She had no idea of the use of cup or spoon.

The development of the twins can be compared:

Clare	Susan
A very quiet, small, child.	'Just the opposite.'
Sat up: 9 months.	6 months.
Walking: 19 months.	13 months.
Talking: no speech, high-pitched squeaks.	'Chatting away for months.'
Sometimes thought to say 'ball'.	
Toilet training: No idea.	Reliable since 18 months.
Health: no illness; practically no increase in size since 2 years old.	No illness; growing rapidly.
Sleep: 'Would sleep all day long if allowed to.'	Normal; wakes early in mornings.

Clare used to spend most of her time running round the room. She played only with a ball held in her hands and, also, balanced it on backs of chairs, etc., appearing to be delighted when she succeeded. She would scream fitfully if doors were shut, especially if she were out in the garden and the kitchen door was shut.

Clare permitted only her mother to touch her, and took no notice of her siblings.

Examination

Clare and Susan were seen together. Susan came into the room violently protesting, she was a tall, well built, good looking girl of 2.9 years, with a wide range of expression of dissenting feelings and a good vocabulary.

Clare was minute for her age and her face was expressionless, except for grimaces.

She took no notice of anything but the toys, except twice to glance at the doctor who made many attempts to attract her attention.

Her activity was distractable and perseverating, and curiously exploratory, testing out relationships between various material objects in the environment. For example, she kept tapping a glass bottle gently on the table, then ran across the room, but several times returned to tap the bottle on the table.

Clare was very active, with agile and graceful body movements. Her hand manipulation, however, was that of a 12-month-old child. She pounded round the room describing a triangle measuring 6 ft. \times 6 ft. \times 3 ft. Once she stopped still for 20 seconds, grimacing and blinking. Other stereotyped actions included rubbing her fingers on paper.

The mother's attention had been drawn to Clare during infancy because she slept all day, in contrast to Margaret and Susan. Susan took notice of her parents and had 'always got into everything', whereas Clare had always been aloof. Recently Clare had sometimes sat on her mother's knee; or turned her head in a listening gesture when her mother spoke to her, without understanding what was said. She took no notice of her father.

At 2.9 years Clare fed herself with her fingers and smelt everything before eating it. She would take a sweet in her fingers and put it in her mouth after smelling and looking at it. She carried objects around in her hands, for hours at a time, as if they were talismans.

She would sleep all day if left undisturbed. Her waking mood was usually restless and grizzling, and she had 'off-days' when she would scream intolerably for hours.

Comment

Clare showed many features in common with Norman, but was altogether more active. Clare's state stood out in very sharp contrast with that of her more successful twin; and the comparison shows that the onset of Clare's difficulties was during the first 3 months of life. Her weight gain was 'disappointingly slow' in spite of her mother's discrimination in her favour by continuing with breast feeding for 10 months.

Since that time the consistent clinical picture had been that development continued by maturation only, with a minimal acquisition of skill. Clare perceived little and conceptualized nothing except automatic and ritual actions. She was a typical case of 'anomalous idiocy' of a hyperkinetic, out-turning pattern of temperament.

SOCIAL INSTINCT FRUSTRATION

Raymond W. (12) 16 months

Raymond was the illegitimate son of a divorced woman and had been in a large Children's Institution since the age of 10 months.

The mother, 21 years old, had children of 4 and 3 years by her husband, and she had had 7 convictions, mostly for stealing. Her own father was killed when she was 4, her mother had led an immoral life, and she was brought up by her grandmother who died when she was 15. She married at 17 while pregnant, against the wishes of her husband's family.

The mother greatly resented the interference of her mother-in-law; there were several marital separations and she twice attempted to abandon her children. After

the birth of the illegitimate child her husband had obtained a divorce; but the putative father disappeared.

At 8 weeks Raymond was taken with his mother to prison, where she served a 6-month sentence for theft. Upon release mother and child spent a few weeks in a Diocesan Shelter. When he was 4½ months old, a pædiatrician had considered that he was mentally backward.

At 9 months he was admitted to a receiving centre of the Children's Institution, and after 3 weeks transferred to the main reception centre, some 120 miles distant. After a few days he was sent to the institution hospital for 3 months and, at 13 months, to a cottage home, being transferred to another at 20 months. This Home was staffed by a changing population of student nursery nurses.

At 10 months he would take only 'slops and National Dried Milk'. He screamed a great deal, had a chronic cough, and vomited occasionally. He was not sitting up, nor raising his head off the pillow, neither had he any teeth. The anterior fontanelle was closed.

He contracted measles, bronchitis and chickenpox in quick succession. At 9 months he weighed 20 lb.; 10 months, 20 lb. 7 oz.; 16 months, 22 lb. 5 oz.

At first when in the cottage home he screamed at night and, as the nurse said, 'he was not with us'. He played only with his hands and feet, ignored his toys and made no distinction between the nurses. His mood was always serene.

At 16 months, Raymond crowed and laughed to himself, sucked his hands and touched his feet; he sat up unsupported. He looked up when his name was spoken and at an unexpected noise. He looked pleased when caressed or picked up. Offered a coloured block, he just let it fall from his hands repeatedly, but he grasped a finger quite firmly. When held to the floor he made stepping movements but no effort to stand. When stood on the floor propped against a chair, he looked miserable. As his feet slipped he groped at the chair. His happy expression returned instantly he was picked up.

At 17 months he was observed sitting upright on a mat, with a withdrawn, pre-occupied air. He rocked and played with his hands, face and feet in a room full of children. He responded indiscriminately to adult attention. He laughed and crowed, but when hit on the face by another child, he made no response. His hand co-ordination was fair, and he managed to take a cup in his hands. He showed a certain remote interest in the environment. Though his level of motor skill might be placed as high as 12 months, his social level was less than 6 months.

He was thus showing a primitive withdrawal, apparently due to lack of orientation from the early months. His capacity for response was judged to be not entirely absent. Motor development might proceed by maturation alone, devoid of social orientation, with the usual result of remote, patchy and unreliable behaviour.

The Children's Home, within its limited capacity for special staffing, then attempted to give him unremitting attention for 24 hours per day, with daily periods of specialized individual play. Raymond was seen again at the age of 25 months. His improvement was obvious. He had recently acquired walking by himself. His gait was still unsteady, but his bodily movements were supple and his manual manipulation good. He was very small, and with his pale, sallow face and drawn, set expression and luminous dark eyes he made a striking impression. As previously, he was slightly responsive though entirely indiscriminating.

He allowed himself to be joggled on the knee and cuddled, and lapsed into 6-month-old behaviour, but was glad to get off the knee again. He quickly became more particular in his response to the adult and kept bringing objects to be held. He played happily in his own group, but independently. He became almost boisterous and chuckled like a 6-month-old baby when picked up and tossed into the air. He was still wet and dirty.

Evidently someone had worked hard to enter into contact with him, for he had some glimmer of appreciation that human beings differ from inanimate objects. He was still very retarded, with no capacity for loving relationships as yet.

Comment

Raymond differed from Norman and Clare, though his patchy and anomalous defectiveness resembled theirs. First, Raymond's environment failed to provide him with nurture and orientation experiences during his first 16 months. He was illegitimate; lived for 4 months in a prison nursery; was 3 months in a temporary shelter with his mother; was parted from her and subsequently suffered four changes of care and location within 4 months, and a fifth 7 months later. Raymond's social instinctual drives neither found any objective nor gained any satisfaction. His primary egocentred drives remained unmodified and he withdrew into the exploitation of primitive body sensation, to the exclusion of external relations. His only object was his body, but he could not perceive or conceptualize this as a unity.

The second difference was the appearance of weak integrating tendencies in Raymond's case. In the last few months he had begun to perceive objects and create a primitive body image. This process was hindered by his repeated changes of location and care.

Naturally, at 20 months, his object relationships were still shallow and lacking in particularity. Nevertheless he was putting out feelers, entering into some shadowy relationships. His chances of approaching normality were not high and would be reduced each time the adult in charge of him was changed.

In a large children's home, even with a cottage home structure, only children with strong out-going drives will be able to make use of their meagre opportunities for relationship formation. Other children will suffer cruelly from repeated breaks of their maternal relationship and will be retarded, babyish and lacking in confidence. Children with weak social trends, or separated in early infancy commonly show either an autistic withdrawal or a hyperkinetic preoccupation, or like Raymond, something between the two. On the whole, Raymond showed a slight degree of integration.

WITHDRAWAL

Muriel L. (13) 3½ years

Muriel was the stronger of binovular twins, which threw her condition into peculiarly sharp relief. Her father was a lorry driver, her mother a shorthand typist before marriage. There was another sister, 3½ years older; housing was good; and there was no family history of mental disturbances.

The mother was 32 at the birth, she had a sick pregnancy and suffered from swollen ankles. Labour was 4 weeks early and lasted about 4 hours. Muriel weighed 4 lb. 15 oz.; Eleanor 4 lb. 11 oz.

Muriel was so much the stronger of the two that after 8 weeks' breast feeding, the family doctor advised putting Muriel on a bottle to give Eleanor a better chance. (Eleanor was breast fed for 8 months.)

One week later Muriel was admitted to hospital for 4 weeks, with gastro-enteritis and bronchitis. Visiting time clashed with Eleanor's feed, and the mother visited Muriel only once in 4 weeks. On discharge she was 'in a disgusting state—her buttocks were covered with boils and she smelt horrible'. She lay for two days almost in a coma and took no food. Her head seemed to roll over on to her right shoulder and her right cheek twitched. This passed off but she had an irritable bowel for several weeks.

Development

Muriel

Smiled: 6 weeks

As a *tiny infant* was good, easy and quiet, giving no trouble.

Teething: normal, good teeth.

At 8 months could drink from a cup and play with a rattle; at 3½ years she took a spoon into her mouth, but seemed to lose control and drop it.

Sat up at 10½ months unsupported.

Crawling: never attempted.

Stood: not unsupported.

Walking: tried—no sense of balance.

Toilet training: from birth, used pot but could not ask.

Talking: a few words at 12 months, but lost ground after 2 years. Vocabulary: 'Mummy', 'Dad', 'Bow-wow', 'Dolly', 'Teddy', 'Hullo', 'Door', 'Coat', 'Oh, there it is'.

Eleanor

6 weeks.

Grizzly and difficult, later demanding.

Normal, good teeth.

Went ahead steadily to learn to feed herself in a normal way.

At 8 months unsupported.

At 10½ months.

At 16 months.

Reliable at 18 months.

Learned easily, nursery rhymes at 17 months, seemed a bright, forward child.

At 19 months, Muriel's head was small, but the skull X-ray was normal. She had bilateral ptosis. She spent much of her time sitting still, dribbling and spitting; but had crying fits up to the age of 3 and would bite her arm. She did not join in other children's play.

At 3½ the mother said: 'She is a lovely looking child and the picture of health, but she seems to have gone backwards and has a dreary look about her.' She first noticed the difference between the twins at 16 months.

Examination 3.6 years

Muriel sat passively on the psychologist's lap, spitting slightly and making sucking noises. Her attention could not be gained, her eyes were not focused on the test material; she paid momentary attention to the ringing of a bell.

Psychiatric examination was undertaken in the presence of both parents, who remarked that she gave no real trouble. She did not attempt to walk on her own. She

had once crawled across the room by herself, and could stand up, holding on. She fed herself with her fingers and would not use a spoon.

She sat up unsupported, wriggled and kept her fingers in her mouth. She looked at the doctor momentarily when her name was called. She appeared preoccupied with internal fantasy—made crowing noises, little screams and minor paroxysmal movements, facial grimaces and so on.

Comment

The element of deprivation was marked. When breast feeding was interrupted, she became ill and lost her mother, who was too preoccupied with the then ailing twin to keep in touch. Muriel's social instinct was completely frustrated, and she had never recovered. Maturation had proceeded but learning had been patchy. She had more skill than a mental defective and greater orientation in social relations than an 'anomalous idiot'.

However, her slight integrating reaction had tended to get less since the age of 2. She was losing ground in her social relations and almost certainly would become profoundly autistic—an example of deprivation psychosis of childhood. Her physical beauty should be noted.

WITHDRAWAL

Maureen M. (14) 5.5 years

Maureen had brothers 5 and 2 years older, and 3 years younger than herself. The family history was not significant; they lived in a roomy suburban villa with the maternal grandparents.

The father had been a regular soldier and the mother had had to return to the U.K. alone with the boys when 6 months' pregnant with Maureen. She was very sick during pregnancy and had fallen out of her bunk at 8 months. The period immediately before and after the birth of Maureen had been a very great strain.

Early Development

Birth at term; weight 5 lb. 8 oz.; blue baby, at first very quiet. Labour uncomplicated, rather prolonged. Maureen thrived on National Dried Milk, becoming a big heavy child. Weaning was easy.

Her development was patchy. She sat up unaided at 9 months and seemed to have difficulty in holding up her head. She did not grasp the cup, her hands appeared stiff and awkward, and many months elapsed before she fed herself. She walked at about 16 months, but for months with a clumsy gait and constantly falling. Toilet training was easy and she managed herself. She dressed herself except for buttons.

She talked little until 3 years old, but could recite nursery rhymes until she went into hospital (see below). At 5½ years she said only 'goodnight', 'all right', and 'come here'.

Interruptions in care. Maureen spent one week in hospital at 6 months with bronchitis and abscesses in her ears. Her mother noticed no ill effects. At 13 months she had measles at home and her mother considered that this impaired her eyesight. When she was 3 years old, her mother was in hospital for 7 weeks with obstetrical complications (the youngest child was born with a 'broken leg'). Maureen was left with the

Indian ayah to whom she was attached. Maureen herself was in hospital for a few days, but the after effects are not known.

When Mrs. M. returned home Maureen rejected her mother, but when the new baby was being nursed, she would try to push him away. She became so difficult that she was actually sent to a Mental Hospital for about 1 month. There, she screamed without cessation, night and day for a week, and refused food. She was heavily sedated and forcibly fed. Maureen took no notice of her mother's weekly visits.

This paroxysm of disturbed behaviour left Maureen remote, unresponsive and rigid. Her mother remarked: 'Before baby came, Maureen was much more normal—then for a whole year she seemed to go backwards and did nothing. At 2½ she was a beautiful baby and seemed perfectly normal mentally.'

Both elder children were doing well at school—the eldest suffered from asthma. The youngest child, aged 2½ appeared lively and not handicapped by his damaged leg. At the time of examination, family relationships were good and their economic position reasonable.

Maureen's Personality. The mother considered that Maureen was rigid and unbiddable in her behaviour, hard to communicate with but, on occasion, surprisingly sensible; for example, when feeling unwell, she would sometimes put herself to bed.

Maureen's play was not destructive. She enjoyed building toys and bricks, a blackboard and chalks, but was frustrated by her unhandiness. She especially loved playing with water. Lately, she had made horrible grimaces. She got on well with the other children, who neglected her and left her on her own.

Maureen was seen at home in company with her younger brother. For most of the time she was unapproachable, and sat dextrously balancing on the rocking horse, with one leg over its back and the other between its belly and the stand. She grimaced as if communing with unseen people.

Her devoted ayah kept trying to get Maureen to 'do this' or 'do that', saying loudly and firmly; 'Maureen write on the board' or 'Maureen beat the drum', to which Maureen made some slight response. Ayah's manner, though patient and in contact with the child, was certainly dominating and in sharp contrast to the mother's lack of confidence in handling Maureen.

Maureen did not speak but repeatedly peered up at the adults with her head down, as if her sight were bad. It was said that when upset, she would grunt and might plunge at one of them. She disliked bright light.

Examination 5.5 years

Psychological testing proved impossible, because she would only carry out her own intentions with the test material. Once she paid some attention when the psychologist joined her in whistling, but did not respond to other auditory stimuli. She appeared to understand simple language—picking up the ball when asked.

She was a large, well-nourished, red-faced child whose idea of managing stairs was to put her foot on the banister and launch herself into space. Held by the doctor's hand, she half walked, half fell down the stairs. She was unapproachable, ranging round the room restlessly and unresponsively. Eventually she settled by the sink, wetting a rag, squeezing and occasionally sucking at it. This would have gone on indefinitely and she became very wet in the process. She was passive when rocked

on the knee, grimaced, did not attempt to climb down, but gave a troubled, chuckling cry.

The mother in her detached way had clearly minimized her difficulties with Maureen, trying to believe that all Maureen's troubles were due to jealousy of the next baby. She emphasized that whereas once Maureen had repeated nursery rhymes now she had no more than 10 words. She related Maureen's negativism and remoteness to her stay in hospital. Sometimes Maureen responded to a cuddle.

Comment

This baby's birth had been attended by family disaster. For 6 months, Mrs. M., the ayah and three children lived in a single room and had serious money difficulties. With a distraught mother and a domineering ayah, Maureen lacked the body-learning satisfactions necessary for relationship formation. A weak social instinctual drive, as evidenced by lateness in acquiring motor and social skills and passivity, completed her failure in relationship formation, and resulted in weakness of her body image and identity formation.

Her separation at 2 was followed by reaction of regression and hostility so violent that it not only disintegrated her own weak system of relationships, but also destroyed her social environment. She was sent to a mental hospital, of all unfavourable places, for 1 month. On her return, neither party could resume the relationship, and her affective life and libido became entirely withdrawn from her relationship system and centred in herself.

All that remained at 5½ were an inborn maturation pattern, some relics of previous skills and an autistic capacity to react repetitively to repeated and strong stimuli. There was no sign of any integration and little hope of any later integrating reaction based on cognition. Indeed, it was more probable that developing intellect would increase the psychosis, because of her lack of contact with external reality.

WITHDRAWAL AND DISINTEGRATION

Angela C. (15) 14½ years

Angela came from a working-class family that had been living in a house with a garden for 2 years, after having had only 2 rooms.

Pregnancy was normal but delivery at term was prolonged and difficult. Birth weight, 8 lb. 2 oz. 'A cuddly happy baby.' Breast fed, 8 months; gained steadily; weaned easily, but she had always refused milk in any recognizable form.

She smiled at 3 months; sat up unsupported at 7 months; stood at 12 months; and walked alone at 15 months, but was always terrified of steps; clean and dry at 12 months. Speech was exceptionally backward, she used only a few words, mostly repetitively and inappropriately.

Mr. C. went away on war service when Angela was 5 months old and did not return until she was 5 years. Her mother became depressed and she thought that Angela also missed her father.

At 15 months mother and child moved into lodgings. The landlady appears to have terrified the mother. In order to be out of the way, Mrs. C. used to walk the streets with Angela and when in the house kept Angela absolutely quiet. She did everything to prevent Angela from ever crying.

The mother said that the landlady kept on pressing her 'to put the child away', which raises the possibility, at least, that the mother's social relationships were poor and that Angela was already eccentric or odd. Photographs of Angela at 15 months gave no clue. The mother thought that one foot and one arm seemed slightly paralysed.

Mrs. C. remarked 'Angela seemed to go right into herself and would not let me play with her. She was very unhappy—if you spoke to her she would bite her fingers, but even as a little one she did not cry much. She gave very little trouble.'

Her general progress was so poor, she was unresponsive and had no speech, that she was not sent to school at 5. At 7 she spent 6 months at a residential school for difficult children, but made no progress. It was reported:

'Angela showed no distress at parting with her parents or at the strangeness. She took no notice of her mother, but responded to her father.

'She showed neither fear nor dislike of the other children but was inclined to knock over the babies. She joined in no group activities, but now and then got excited, running about with small steps, crying feebly and wringing her hands.

'She was negativistic, and suspicious of visitors. She ate with her fingers. She was rarely still. She only said "Good-bye" and "water", and could not dress herself.'

After 6 weeks at this residential school a great improvement was claimed. She was reported to watch the other children but 'not yet actually to co-operate'. A special teacher reported on her absent-minded smile, muttering unrecognizable words, and 'licking her finger furtively'. Her gestures and words were only half completed. She quickly learnt simple routine nursery school occupations, made no progress with speech, but understood more of the routine phrases. She was more controlled and was rarely distressed. She showed pleasure on seeing her parents and was upset at their departure, but her affection was without discrimination. The headmistress remarked 'I have been deeply impressed by her development from day to day. If this progress continues, I shall be more than satisfied.'

Within 2 months of this optimism, Angela had been sent home and admitted to a day E.S.N. school. Two years later she was sent to an M.D. occupation centre, where, with two transfers, she remained. An educational psychologist who retested her at 9.9 years reported: 'Angela still untestable, and in my opinion low grade M.D. and ineducable.'

At 14½ Angela was talking more, but mostly gibberish or catch phrases from the wireless. She had never played with toys, but spent her time day-dreaming, looking at books or singing to herself.

She was most particular about cleanliness and fastidious about underclothing. She made her own bed, dressed herself, and could find her own way to the occupation centre. She seemed to enjoy riding on one roller skate.

At a home visit, the family appeared united, and James, the 10-year-old brother was bright. Angela was extremely withdrawn and mumbled to herself. When asked to show her roller skate, she fetched it at once, otherwise she resembled a placid, low-grade ament.

Hospital Examination at 14½ years

The psychologist reported that she was left handed: she merely echoed verbal questions, but attempted performance items. Her response to the Merrill Palmer

Scale was grossly defective and she showed very little ability to learn from her mistakes. Her scores in verbal items were relatively the lowest. She responded to simple directions. M.A. 3.11.

Angela was big, heavily built, dysplastic and with a strong body odour. Although appearing withdrawn, she came readily enough into the room and gave a number of sidelong glances at the doctor, smiling internally. She showed echolalia—repeating the last word; and echopraxia—compulsive imitation of clapping, and hand rubbing. When asked to draw she made about 150 crude and irregular pencilled rings, overlapping and often incomplete. She would have gone on indefinitely, looking up frequently, grimacing and knitting her brows.

Her mother's remarks were illuminating: e.g. 'Up to lately she used to fight against us.' 'Now she doesn't say any more than she used to, but she sort of speaks directly to us.' 'She speaks plainly and doesn't stammer, but she doesn't use her speech.' 'She knows everything you talk about but she cannot make herself tell you. She can do everything in the Occupation Centre, but if shown anything she goes stiff with worry.' 'She knows everyone in the family and even remembers my sister who has been in America for 6 years. Her father is devoted to her and so is James—he treats her as a child who has been ill. She doesn't give us a bit of trouble.'

At the Occupation Centre Angela was withdrawn and almost completely uncooperative, except with feeding.

Comment

Functionally Angela was an imbecile, but her history showed many anomalous features. Angela's earliest body learning experiences were satisfactory, but at 5 months when her father went away, her mother's depression suddenly severed Angela's developing social relationships.

Commonly, the severing of a developing relationship has a more disintegrating result than failure to establish one, which latter may be followed by an integrating reaction. Angela's growing affect was turned in upon herself, but the actively hostile environment, some of which must have been reflected in her mother's attitude, did not delay Angela's developmental landmarks, except for speech—the chief organ of social communication. But Angela developed an uncoordinated, excited and hostile reaction pattern which, at 7 years, in the neutral atmosphere of a residential school settled slightly, for a brief phase, but left her underlying character deformity unchanged.

Subsequently, disintegration continued, Angela became more remote, her affect even less organized for external expression and her reactions to stimuli diminished. The resulting quietness, as often happens, was mistaken for improvement, but was really a dementing process, though socially less awkward. The prognosis was hopeless.

WITHDRAWAL AND REINTEGRATION

Mark N. (16) 7.5 years

Mark was referred by a pædiatrician because, although he had learnt to read before he was 5 and was remarkably advanced in mathematics, he had been late in his motor development and was unusually clumsy.

Mark was by 2 years the elder of two sons of highly intellectual parents, both

graduates in mathematics. Home circumstances were comfortable; but both parents were united in their over-intellectual approach to life and the mother had had a bad relationship with her own mother. When Mark was a baby she had obviously been at a loss with his babyishness.

The pregnancy was easy, the mother was aged 24. Labour was very prolonged and rather frightening; lower segment forceps; weight $9\frac{1}{2}$ lb.

The happiness of Mark's infancy was marred by great feeding difficulty. He slept almost unceasingly, never wanted feeding. The mother said 'feeding was a terrific struggle because I had no confidence, he kept dropping asleep and I was flapping about'. Breast fed 9 months. Weaning was easy but since 18 months he had been awkward over food. He disliked meat and fish and could not tolerate fat; Mrs. N. said, 'Being my first baby I was inclined to do battle with him. I wouldn't now.'

Motor development was late. Sat up and started crawling at 9 months; walked at 20 months; speech: put two words together at $2\frac{1}{2}$, comprehensible at 3; still had poor vocabulary at 5.

Paul, by contrast, was altogether more robust, more out-going, better at everything than Mark and 'has the knack of getting on with people'.

Mark's personality, as seen by his mother, was complex. He did not come out with his feelings and was most unaggressive at home. He was stubborn and self-willed, but very generous; had little imagination and played repetitive games involving one simple idea. He had great application, taught himself to play the recorder, though he had no music in him. He collected stamps, was interested in geometry and five-figure logarithms, astronomy and the position of the stars; and railway time-tables.

It was obvious that he had no idea how to conduct human relationships. With other boys he was 'inclined to be bossy, priggish and self-righteous', but some of the teachers at school liked him. The other boys set on him for getting them into trouble. He appeared to his mother always to be provoking, trying how far he could go before she got angry.

His infant school headmistress reported that Mark was extremely insecure, cried easily and never laughed or played spontaneously with the others. He seemed at school to enjoy getting others into trouble and to gloat when he succeeded. It was thought that he considered himself enormously superior to the others. He was said to be domineering and to have no sense of humour; to be excessively upset if he was ever found in the wrong.

The junior school headmistress was prejudiced against the parents, whom she considered to be atheists, communists, and over-intellectual; but the whole staff thought that Mark had never been allowed to be a baby and was starved of bodily thought. Academically Mark was good, but hopeless at physical activity. They thought his speech was strangely slow, precise and pedantic, with hissing sibilants.

Some idea of the irritant effect of this boy upon the un-understanding can be gleaned from the statements of the headmistress of his junior school after he had been there 1 year. 'He is arrogant and full of his own importance and cleverness. The other children dislike him because he is sure that he is outstandingly clever.' The headmistress completed her account by scathing criticisms of the infants' school for letting him have his own way and of his mother 'who is very unwise and excitable'.

Examination

The psychological test was most revealing: Revised Stanford Binet Intelligence Scale. Form L. C.A. 7.5; M.A. 10.2; IQ 137. Reading age 10 years; Scatter: Year 9 to Average Adult; he failed on visual absurdities and passed all items involving mathematical concepts. He was relatively poor in visual memory items, but good in non-verbal abstract reasoning.

Retested at 8.9 years on the Wechsler Intelligence Scale for Children. Verbal IQ 139; Performance IQ. 125; Full Scale 136

At 7½ Mark was a pale-faced, small child deeply immersed in reading *Robin*, from which he had to be extracted. He answered questions in a loud, unmodulated voice. He made two spontaneous remarks in a loud voice: 'My family seems to be late in losing its teeth,' and '*Robin* has changed its lay-out'. He developed a sudden excitement as he described the changes in detail, then the interest evaporated. For the remainder of the interview he spoke in monosyllables with his eyes glued to his paper.

Treatment added greatly to our knowledge of this child. First, his mother learnt to appreciate more of the importance of the emotional and bodily needs of young children. Secondly, we became aware of the enormous gap between Mark's intellectual understanding and his feeling tone. His intellectual grasp could be phenomenal. He discovered the game of chess and within one month was able to reproduce from memory the first ten moves of five master games; but he could not adjust to his opponent's making of a foolish move. He would play simpler games with slavish adherence to rules and total absence of constructive imagination, and he was quite extraordinarily unhandy in all practical motor activities.

Treatment was directed first, to humanizing his interpersonal relationships and secondly, to improving his body image and control. The first objective was approached by playing games with him, mixing things up, teasing and interpretation. He responded at first by solemn incomprehension, but quickly revealed a lively sense of humour, though it needed fostering. The second objective was approached by physical re-education which proved a very useful asset. At a later stage, remedial education in English was given.

On the whole, results were very encouraging and Mark showed a progressively improved social orientation.

Comment

Mark presented a most interesting example of the effects of a baby's failure to establish infantile social relationships. He had become extremely retarded in the instinct modification and environment exploration experiences of early childhood. The cause of this failure is speculative—Mark was a sleepy baby and possibly possessing only weak social instinctual drives. Mrs. N. was anxious, with poor empathy and little body feeling as a mother. Mark grew up a stranger to the harmonizing of bodily experiences with affect, and he almost totally lacked empathetic experiencing of the existence of other people.

However, he was rescued from otherwise inevitable autism by two factors—an out-turning temperament and an outstandingly high intelligence. In the early latency period of intellectual growth his social relations developed on a basis of

cognitive perception. His affective lack saved him from realizing fully the dislike and hostility that his behaviour provoked, at first, in school, where his headmistress inevitably mistook his cluelessness for overweening superiority feelings. Increased body confidence and security enabled his underlying gentle good nature to reveal itself to the other children, and the whole tone of his social relationships improved.

Chapter 8

The Modification of Instinct

THAT phase of a baby's life during which all his wants are found in satisfactory feeding and sleeping rhythms lasts only until he shows recognition of his mother, when some of his feeding affect begins to be transferred to her. There follows the beginning of environmental exploration by the child; first, by the use of the mouth; then successively adding the hand and the eyes in combination, with the balance of importance shifting to the eyes.

The most significant outcome of this progression is the two-way process of identity establishment. First, the child perceives the mother, then objects in the environment, including parts of his own body. The baby can be observed progressively treating his mother not only as something whole and distinct from himself, but as something distinct from feeding and bathing. He quickly shows an integration of hand, mouth and eye movements, and using eyes and hands together as tools he begins to discover some of the properties of objects within reach. His grip is first purely palmar, then by thenar apposition, then by thumb-finger apposition, by which time the finger-tips have become more refined organs of sensation. The child is then prepared for that detailed exploration of the surroundings which so strikingly characterizes the period from 6 months until 2 years.

Between 5 and 9 months the baby becomes master of the objects within the reach of his hands, but outside this range he is limited to a visual percept of his mother and of one or two familiar adults. He is responsive to attention but shows little discrimination. Observers commonly overestimate the capacity of the first-year baby to conceptualize objects outside his arms' reach.

These important developments contribute to the organization of the child's motor impulses, whereas previously his motor activity has been unorganized. He can stretch out a hand, grasp a rattle, shake it, put it to his mouth, look at it closely, shake it again and put it down. Thus it is clear that he can perceive an object, experience impulses in relation to it and make appropriate movements. As these experiences become organized, memory develops and enables him to begin to conceptualize action with the effect that he will have spontaneous impulses to execute movements as a result of inner mind activity.

The baby's motor impulses in the service of instinct constitute his *aggression*

or *aggressivity*. By about 9 months his aggressive impulses can have direction and force, and become charged with affect, as shown by the hungry child's aggressive impulses to secure food. Aggressivity at first serves ego-building instinct; but when it comes into the service of social instinct it needs control. The development and control of aggressivity is a dominant *motif* in child development and its disorders.

The immediate effect of the eruption of teeth is that weaning becomes necessary; but there are other far-reaching implications—for the baby with teeth has a weapon of offence, the first in his possession. The weaning child already has a certain capacity both to identify objects and himself, to direct his aggression and bring it to bear upon an objective, and since teething gives him a weapon of some strength, control of aggressivity becomes important to the child. Weaning, with its modification of instinctual patterns of behaviour is liable to arouse strong feelings and the situation is, therefore, potentially explosive.

THE PSYCHOLOGICAL SIGNIFICANCE OF WEANING

The baldest description of weaning is that it involves varying, at the behest of the mother, a familiar procedure by which the child's hunger pain is allayed and his feeding pleasure gained. In the case of well-cared-for children the first interference with suckling is neither sudden nor drastic, for ordinarily something is bound to cause a feed to be delayed and the child to suffer extra hunger pain, with the effects of which both mother and child must deal. The resulting experience is important to both parties. The notion that pleasure is enhanced when preceded by pain is as old as poetry or religion and it seems to be true of babyhood. By suffering together a minor increase in pain, child and mother experience an increase in mutual pleasure and satisfaction that will encourage the baby to accept from the mother the little alterations and frustrations of instinctual rhythms that may occur. Gradual introduction to change is essential, for the baby has but a limited capacity to adapt. Spoonfuls of solid food when the first edge of hunger has been dulled by sucking would obviously be preferable to a sudden change. Edible hard matter, teething rings and so on, will give oral pleasure to the baby. It is a constant feature of extremely withdrawn and of autistic children that they do not use their mouths for exploration—only for suckling or finger sucking. They often will not tolerate anything else in their mouths. The baby needs the maternal relationship to help him with using the mouth as a biting organ, and with the transference of some of his feeding pleasure on to biting.

The wise mother helps the child by a certain informality and variation, supporting him and compensating him in any difficulty. From the baby's point of view, weaning is an arbitrary cessation of a well-practised and satisfactory mode of gaining instinct satisfaction. Instead of sucking, something new is substituted, a skill which the child does not invariably acquire easily.

The key is in the mother-child relationship. A confident mother will give her child confidence to acquire the necessary new skill, after a very few attempts. Minor frustration successfully withstood results in greater eventual satisfaction, and this is an important learning experience. To suffer hardship or discomfort in relation to a beloved object, now, in the expectation of compensation, later, is an important moral incentive.

The greatest compensation that the child gets is the enhancement of his relationship with his mother. Young children are particularly sensitive to maternal pleasure and displeasure. Success in weaning will greatly increase the mother's confidence and pleasure in her baby, and will give a great build-up to the latter. Conversely, failure may undermine confidence and correspondingly undermine the baby's developing ego-strength.

The degree of instinctual modification which results from weaning is no more than an alteration of the mode of achieving instinctual satisfaction; the satisfaction itself is enhanced. This is only a little step towards sublimation, which will involve the abstraction of instinctual goals and the toleration of indefinite delay in reaching satisfaction. But weaning is the first significant interference with an ego-building instinct, which fact gives it a particular importance. It is noteworthy that, just as earlier the baby's social instinct modified his ego-building instinct in the displacement of feeding affect on to the mother, at weaning also the social relationship modifies the pattern of the ego-instinct. Paradoxically, modification of ego-building instinct by social relationship increases the child's ego-strength through his growing identification with his mother. Conversely, failure of social instinct to modify ego-instinct will result in weakening of the ego, for the child will remain ego-centric and in an infantile state of fixation at a level of unmodified pain-pleasure.

The children discussed immediately above (cases (10)-(15), pages 99 to 110) had in common a persistence of difficulties over taking solid foods. They tended to resist the introduction of solid objects into their mouths and to fail to take to biting in order to satisfy their hunger. These cases illustrate a grave failure in child-mother relationship formation, but it is more common for the relationship to be impaired rather than a total loss.

THE IMPAIRMENT OF EARLY CHILD-MOTHER RELATIONSHIPS

The first evidence of impairment of the developing child-mother relationship can sometimes be seen in the child's reactions to unsatisfactory feeding between about 4 and 6 months. These may be of an in-turning or an out-turning nature. The in-turning baby will be relatively unresponsive and will fail to form a really adequate relationship with his mother. His indifferent appetite may present a feeding problem and weight gaining troubles, but the trouble may easily escape notice if the mother is not clear about what to expect from a baby. The fact that he is withdrawn and unresponsive may not

impress her or anyone else should he not be causing any definite difficulty other than not thriving properly.

In contrast, the unsatisfied out-turning child will show his disturbance very emphatically in his behaviour. His restlessness will increase and he will become a disagreeable, crying, demanding baby who never seems satisfied. He may gulp down his food so rapidly that he regurgitates some of it, so that his mother will believe that he is not getting enough. He may create a fuss whenever the usual routine, however little satisfactory this may be, is not followed; and in general, he will be a most stormy baby.

In cases of moderately impaired relationship, the babies' behaviour will often be fairly normal and many will show a spontaneous trend towards resolution of the difficulty. When the trouble is more serious, weaning will provide the great test. In the case of impairment, rather than failure of relationships, the disturbances may be relatively less at the time of weaning but the later consequences may be very far reaching and affect every aspect of life.

WEANING DIFFICULTIES

Children show three main types of reaction to weaning difficulties, an *in-turning* and an *out-turning*, and a third, mixed, reaction which we may call *inhibited*. An *in-turning* weaning reaction shows up in the baby's withdrawal and loss of interest in food. He is hard to persuade to take food by spoon, and unadventurous in seeking to feed himself. He may cling tenaciously, if undemonstratively, to a night bottle feed, which the mother may allow out of a feeling that he needs extra comfort. Overt difficulties may not be serious, perhaps not more than a lack of interest in food, but behind this the child will have a general tendency to be retiring and to have a cautious, conservative attitude towards innovations.

An *out-turning* reaction is more dramatic—the child is cross and protesting against the change. With some degree of adjustment he may become greedy and independent—seizing the spoon and ploughing away, crossly, on his own. With less reconciliation his anger about weaning may affect all his love relationships. This child's hostile attitude to innovations will be a matter of open rejection, or greedy overcompensation. His strong, angry feelings, thoroughly aroused by the feeding change, may play havoc with appetite and interest in food, and also with family relationships.

The third, or *inhibited* reaction is less common but perhaps more serious, ultimately. The danger of an inhibited reaction is greater among out-turning children, because in-turning children are less likely to get into the disturbed state that will lead to inhibition. Typically the child shows a strong protesting and rejecting reaction to the introduction of spoon feeding and may fight, more or less violently, for a few days. Gradually the battle dies down and the child becomes quieter at meal times. Two or three weeks later, the mother may realize that the child is taking practically no food. And so it goes on;

egocentric compensating reactions, and so on, and the incompetent mother will get the blame. The child may continue at a low pitch of emotional tension and his capacity both to overcome frustration and to control and direct such aggressivity as he possesses will be limited.

TYPES OF ABERRANT DEVELOPMENT IN THE FIRST YEAR

In general, children who have poor relationships in the first year will be regressed and retarded in development. Regressed children tend to lose capacities they have acquired, to behave as younger children, and not to enter into new phases of growth. They may refuse weaning, or show no inclination to explore space. Regression may be cumulative in its effects, because the child will have to enter into new developments with a legacy of difficulty from previous stages. Later developments are likely to be fraught with trouble and the child will appear progressively to be more babyish.

The overall patterns of disturbed in-turning and out-turning children differ. In-turning children tend to be withdrawn and subdued; slow in entering into new experiences; uncertain and weak in their relationship formation; shy and retiring. They often show simple body pleasure-giving activities: rocking, head-rolling, thumb-sucking, comfort seeking and, later, masturbation. Later they may develop a rich internal fantasy life. When an inhibiting reaction is added, the children seem tense and unresponsive, timid about new experiences, clinging to the familiar. They may have night fears and even panic states. Very often such children have tense-looking, strained, pallid faces; they commonly have little zest for life, an indifferent appetite, and retain their babyish ways. It is typical of relationship disorders of the first year of life that the later effects pervade all aspects of the children's life. If any single phrase could sum up the in-turning reaction it would be that the child has a poor personal morale.

An out-turning reaction, naturally, creates more disturbance through these children's restlessness and overactivity. They are never still, even sleep is curtailed, for they take a long time to fall asleep, sleep brokenly and may wake at 5 a.m. all set for another day of turmoil. Their behaviour is 'hungry' in every respect save that of food, for they are commonly too restless at meal-times to attend to a square meal and often have a poor appetite. They are pre-occupied with their surroundings, very distractable, with only a brief span of interest for any one object. Their human relationships may show the same dispersed and shallow character. Usually they have little imagination and when older their interests are practical and active, for the out-turning child will play a lively game of motor racing with Dinky toys, whereas a more in-turning child might use the cars to fantasy about space travel. Disturbed out-turning children often have so much self-compensation or hostility about their behaviour that they are difficult or disagreeable to live with, because of scenes, temper tantrums and general loss of control.

With inhibition added to an out-turning pattern the result may be curiously mixed. The child is approachable and passively friendly, but lacks energy and drive. He is, perhaps, too good-tempered and non-competitive. Later, he cannot stand up for himself and gets bullied by smaller children. This is neither cowardice nor fear of hurt, but fear of losing control of himself, fear of anger and emotion. He may be brave in many other respects. With inhibition and consequent neurotic overcontrol, the child is liable to break down into panic rage states with disturbing after-effects, and to night terrors, sleepwalking and nail biting. Inhibited out-turning children also tend to develop obsessional mechanisms which appear to have the objective of controlling the unruly environment.

SEPARATION OF INFANT AND MOTHER

Much concern has been felt during recent years about the possible harmful effects of separation of young children from their mothers; and the reader is referred to the works of Spitz,¹ Bowlby,² and others. It will be generally agreed that the effects of separation will vary, first, according to the age and stage of development of the child at separation; and second, according to the degree to which the maternal substitute supplies the essential ingredients of maternal nurture.

If separation occurs before any relationship has been formed, the way will be open to substitute formation, given normal social instinctual tendencies. But after about the age of 6 months when, presumably, some child-mother relationship has been formed, separation will often have serious after-effects.

It has been shown that children separated from their mothers between 6 months and 2 years of age, and without adequate substitute care, will show first protest, then withdrawal and regression, and then depression. They may adjust to one or two changes of care, but rarely to more. They may remain capable of quick re-establishment of their relationship with a satisfactory parent after a separation of up to 5 months, but rarely after longer than this.

As a general rule, it might be said that the more satisfactory the relationships before separation, the more adverse the effects, as Spitz has shown in an investigation of 256 children separated from their mothers.

The effects of separation are predominantly somatic during the first year of life. There is usually a marked slowing or stasis of weight gain and growth, and separated children are very subject to alimentary and respiratory disorders. Their morbidity and mortality rates are high.

Longer-term effects commonly include a lack of warmth in relationship

¹ Spitz, R. A., see footnote, page 6.

² Bowlby, J., see footnote, page 6. Bowlby, J.: 'The Nature of the Child's Tie to his Mother', (1958) *Int. J. Psycho-Anal.*, 39, 350-373. Bowlby, J. (1960) 'Separation Anxiety', *Int. Jour. of Psychoanalysis*, 41, 89-113. Bowlby, J. (1960): 'Grief and Mourning in Infancy', *Psycho-Analytic Study of the Child* (forthcoming).

formation and often a hostility which will lead to disorders of control of aggression. Many separated children fail to make the required modifications of instinct, and consequently suffer from lasting deformities of character. These will be illustrated among the clinical examples discussed below.

CLINICAL PROBLEMS RELATING TO THE FIRST YEAR

The foregoing discussion will now be illustrated by clinical examples of problems arising during the first year. Cases (10)–(16) have illustrated severe failure of relationship formation at a primitive level. The next series will illustrate less severe disturbances of relationship formation, in some of which tendencies towards integration and recovery have been relatively stronger, also.

First come four cases illustrating, respectively, the predominantly in-turning and out-turning reaction patterns of first-year disturbances. These will be followed by a series of short cases (21)–(33), illustrating specific problems, such as weaning difficulties, sensory deprivation, maternal separation, and so on.

DISTURBANCES OF RELATIONSHIP FORMATION DATING FROM THE NURSING PERIOD

AN IN-TURNING REACTION PATTERN

Ann T. (17) 3.4 years

Ann was referred by a local Child Welfare Centre, because of restlessness, sleeping difficulties, no interest in her food, irritability, disobedience and bedwetting.

The mother had a rather tense, stiff manner and gave her information grudgingly. The worst difficulty was that Ann had always resisted anything which the mother did for her, ever since she was a baby. Ann never had enough sleep, feeding had always been a problem, she used to scream, fly into tempers and was difficult to manage. The maternal grandmother said: 'My children were never like that. I can't understand it.' The mother countered by saying she was no trouble the week the grandmother was away. Ann used to wet her bed every night and her knickers during the day; she was very thirsty and drank a lot. They lived near a large block of flats and there were many children playing in the courtyard. Lately Ann had just started going out to play with other children and appeared to get on fairly well.

Their three-bedroomed bungalow was in a residential suburb. Ann had had a bedroom to herself until a few months previously, when she had been given a separate bed in her parents' bedroom so that her nightly calls would not disturb her maternal grandmother.

The mother was working from 5 p.m. to 10 p.m. 3 weeks out of 4, in a café; the fourth week she was on day shift. Three weeks out of 4 the father put Ann to bed, but the mother was at home all day before going out to work. She conveyed the impression that Ann came between her and her work.

The parents had been married 13 years before the conception when the mother was 36, but she did not propose to have any more children.

Mr. T. was 35; a lorry driver by occupation, but since being invalided out of the army before the end of the war because of chronic gastric illness, he had worked as a day watchman on light work. He suffered from varicose veins and was under a physiotherapist for sciatica and fibrositis. The light job had brought in less money but had improved his health. He was very fond of Ann but, according to the mother, strict with her. (Mrs. T. thought of herself as lenient.) On the whole, Ann obeyed him. He had been particularly attached to his own parents, who had died when he was about 20.

Mrs. T. was the oldest of four siblings. She was an overdressed person with peroxide hair, and gave a blousy impression. She had a cystic swelling of the thyroid gland. The maternal grandfather had died of heart failure 2 years previously. She said that his health had suffered because the maternal grandmother got him to do a lot of housework and, she thought, exploited him. After his death, the grandmother refused to live with any of her other children. Apart from doing her own room and washing, the grandmother did not help; she took meals with the family and according to the mother, 'She spoils Ann'. The mother was both pleased and annoyed that the old lady would not live with any of the others. Her complaints took the somewhat sinister form of hinting that the grandmother had both hastened her husband's death by overworking him and had made her eldest daughter responsible for the younger children.

She married at 21, and when she conceived 13 years later she had given up hope, for she had wanted a child. There were no pregnancy difficulties. The confinement was easy; no forceps, labour lasted about 15 hours.

Personal History

Ann weighed 6 lb. 11 oz. at birth. Breast feeding lasted for only 6 weeks, and was not a success. The mother said: 'I was very low myself and the baby didn't get on. In fact, neither Ann nor I were getting on well.' Bottle feeding had only limited success. Ann was an unsatisfied, demanding, miserable baby; active and unresting. She would not lie still and be peaceful, but kicked all the time. As the mother expressed it: 'She cried an awful lot—so did I. I used to sit and cry with her.'

Even as a baby Ann did not sleep during the day, and she always appeared to be unsatisfied after feeds. She seemed very forward in her development: she sat up at 6 weeks, walked at 9 months and talked at 18 months; or at least, so the mother said. The mother had great difficulty in persuading Ann to take solid foods and weaning was an uncomfortable experience for both parties. Ann was cross and unhappy and the mother blamed teething, overlooking the introduction of solid food as a possible cause of disturbance. When Ann started walking she became anxious about separation from her mother. Toilet training was a bother, though it had been tried since early infancy. Ann was never dry by night, and after 18 months subject to 'accidents' during the day; she had been fairly reliable over defaecation.

Examination of the Child at 3.4 years

Ann was pale and ill-looking, but not undersized nor poorly developed. After some hesitation she came into the consulting-room by herself, looked back at her mother a couple of times then sat down and allowed the door to be closed. She scarcely played with the toys, but tentatively arranged dolls' chairs around the table; she

looked at the doctor most of the time. She did not speak and would not answer and seemed very inhibited. She was left free to play with the toys for about half an hour, and spent the time playing with dolls' furniture in an inhibited fashion, with no free imagination, and with a minimum of movement. Towards the close of the period, she answered simple questions, such as, 'Who are you living with?' and 'Have you a pussy?' So, at least, she could speak!

The mother assumed that she had come to the Child Guidance Clinic about the blood test and X-ray taken at the Child Welfare Department; so that it took a little time to overcome 'sales resistance'. She appeared to become reconciled to the situation, eventually.

Ann did nothing with the Merrill Palmer Intelligence Scale. She answered simple questions unreliably, giving the answer which involved her the least; and 'I don't know' if she could get away with it. The psychologist's intuitive estimate of the child's intelligence was that she was not very bright.

Discussion

The first point is to consider the reliability of the information. The mother appeared neither intelligent nor cultured and her story was inaccurate in detail. For example, she claimed that Ann walked at 9 months; yet by its very ingenuousness this is unlikely to be a deliberate deception. Mostly her story was consistent, credible, common enough and rather humdrum. There seemed no reason for rejecting any important part of it. The appearance and attitude of both mother and child were appropriate to their troubles.

Heredity appeared to play no part, in spite of the father's long history of neurotic illness. Otherwise the family history was unremarkable.

Clues to Ann's parents' attitude may be found in their own childhood and personal life. Mrs. T. was strongly critical of her own mother who, she felt, exploited unfairly both her father and herself. It appeared that she never harmonized her own relationships; in her fixation upon her father she had turned him into a martyr and in her hostility to her mother had turned the latter—to put the case baldly—into a murderess. Though she complained about having to look after her mother, it clearly meant much to her as an atonement and was not to be interfered with lightly. Another aspect of her childhood legacy was some feeling that she had had too much responsibility for her siblings.

At 21, she had married a man of only 19, who was not a robust masculine type, and whom she described as being particularly attached to his own parents. It looks as if she was impelled into this marriage by unresolved forces arising out of her own childhood. She was emotionally immature, and it appears as if she married an immature man who would not challenge the pre-eminence in her estimation, of her own father.

However, the marriage was fulfilling a purpose, if not quite the normal or usual one. In spite of wishes, children did not come, and their married life showed no great fulfilment of instinct nor emotional liberality. When, after thirteen years, a child was born, they avoided further pregnancies by nearly complete sexual abstinence though, as the mother remarked, neither party had ever wanted much. The inference, so far, is of a poverty or inhibition of instinctual life.

The mother continued to work after Ann was born; 'I wanted the company.' She

was an extraverted person who enjoyed the casual friendliness of the small café more than the more demanding intimacy of the family. During much of her married life she had been the main wage earner. Though it would be unwise to build too much on this possibility, the mother's way of life may have sprung in some measure from a partial repudiation of the feminine role and a veering towards masculinity; which would fit in with her criticism of her own mother and her devotion to her dead father. The view that her repudiation of sexuality was a main part of her solution of an *Œdipus* (or *Electra*) situation finds reinforcement in her subsequent behaviour as a mother.

How does Mr. T. fit into this family pattern? Although 'particularly devoted' to his own parents, he married a girl two years his senior when he was only 19. She never relished the wifely function and increasingly in later years, took more than her share of responsibility. In some ways she was more a father to him than a wife. This impression of the father's immaturity is greatly strengthened by later events in his health history. Although he was only 24 when he joined the army, he remained near home and was invalided out before the end of the war, with psychoneurosis. Since that time he had been a martyr to varicose veins, sciatica and fibrositis and he had given up any pretence of living a full masculine life. In the absence of a demonstrable disability, a day watchman on light work is something of a valetudinarian occupation. However, his meagre money was more than made up by his wife's success as an under-manageress. His taking over the responsibility for bathing and putting Ann to bed both suited Mrs. T.'s desire to oust the maternal grandmother and satisfied his need to be necessary to the family; but as a regular contribution rather than as an occasional treat, it was scarcely a masculine function.

The mother represented the father as being strict with Ann, who obeyed him unhesitatingly. This may have been less objective than arising from her need to think of herself as maternal and loving, and of her husband as paternal and stern. Also, the father's neuroticism may have demanded a rigidity in his relationships and allowed no relaxation of control. In this way, after all, the father could be a man and head of his family, and the mother could reveal feminine weakness. This little tangle, trivial though it may seem, was part of the delicate balance of forces in this family.

Was there any real problem, except in the parents' attitude? Could the mother's complaints of sleeping and feeding troubles have arisen from her exaggerated notions of the amount of sleep and food a child needs? Could her complaint of disobedience and defiance have been settled by the application of a little more discipline, of parental control?

The mother was obviously an uncertain and unwise parent, but even she recognized that Ann was able to go out and play with other children, that her shyness was not central to the family problem. At least the wetting could not be argued away; but repeated examination had found no congenital abnormality, no weakness of sphincter, small bladder, vesical hypertonus, irritability of the vesical triangle, abnormal water metabolism, excessively acid or alkaline urine, urine of low osmotic pressure nor infected urine, nor any other physical cause of enuresis. The only legacy of considerable medical activity had been that Ann had become progressively more frightened of doctors and hospitals.

Medical reassurance had not been enough; each problem taken singly was not

much, but the anxiety engendered by the situation was not inconsiderable. Ann's behaviour suggested that she was no happier about the state of conflict than her mother. Anxious mothers are not easily reassured, if only because the real cause of anxiety is within themselves. Demonstration of the triviality of the child's trouble rarely removes, but usually augments, endogenous maternal anxiety. Besides, these troubles were not trivial to someone living in the house. Every mealtime was a misery, Mrs. T. was worried about Ann's nutrition; nights were disturbed and both parents were apprehensive about loss of sleep. There was bedwetting to contend with.

The family atmosphere resulted from an uneasy balance between Mrs. T.'s partial repudiation of her femininity, which provoked her domineering and nagging behaviour and her feminine compensation, which gave rise to her fantasy of her husband as a strict disciplinarian and of her own inability to control her child. To advise more discipline in such circumstances would be no more than an ineffective tampering with forces not understood by the adviser.

The Origin of the Problem. We have seen that neither parent had achieved an all round maturity, so that a lapse of 13 years between marriage and Ann's birth was unfortunate. Having achieved the form of maturity without its consummation, so to speak, married couples can easily drift into a state of permanent unpreparedness for parenthood. However, this mother reacted happily to the knowledge that she was pregnant; things went well until the baby was born. She did not foresee the implications of parenthood; but realization came all too quickly.

The crisis occurred in the most fundamental situation of infancy. Breast feeding was an unrelieved failure. The mother blamed herself. 'I was very low myself and the baby didn't get on; in fact, neither Ann nor I were getting on well. She cried an awful lot; so did I. I used to sit and cry with her.' She did not have enough milk, and it may be that a mother who is deeply unprepared for maternity and unable to devote herself to the tasks of motherhood may suffer some inhibition of milk secretion. The precise mechanism is not known but this is, at least, a popular belief.

However rationalized, and in spite of cultural sanctions, failure in breast feeding is felt as a reproach; it tends to impair maternal confidence. The well-balanced mother can adjust and can so conduct bottle feeding as to make up for the loss of body contact. But this mother was not well balanced and she did not give her baby proper substitute satisfactions. To Mrs. T. came only the disadvantages, the chores, of baby care; and so she was all set for trouble.

We must now attempt to estimate the effect of Ann's dissatisfaction with her infancy upon her development. We have discussed how children enter into social relationships on the basis of fulfilment of instinctual rhythm associated with pleasure. From the very first there is a bodily erotic component to human love. As the child enters into a relationship with his environment and emerges into consciousness, the mother stands out as the central figure against a background. If satisfaction is derived from this relationship, love develops; and anxiety and insecurity do not emerge even when the rhythms of infancy suffer interference. In circumstances of love and growing confidence, of happy experience with life, change or interference is tolerable. The baby may protest, may fight; but the upheaval will not be damaging. The relationship will endure through the minor vicissitudes of life.

The great task of infancy is to grow out of babyhood, with its helplessness combined with its power to command, into the adult state which is neither helpless nor omnipotent. Mature adults are neither daunted by difficulties, nor upset at failure; but in order to become mature, children need protection from environmental conditions too severe for them. As children grow from stage to stage, the strength of parental love will enable them to leave behind the dependencies and ties of each stage, in their progress towards the next. Love breeds confidence without which progress will be difficult.

Under social pressure to grow up, the failing child clings to his existing pattern of behaviour or may range backwards to an earlier phase in which he found more satisfaction. Whichever occurs, there will be an ever-increasing gap between advancing social demands and the child's level of response, a gap which gives a unique urgency to the maladjustments of childhood. The child is under pressure from his own growth as well as from the expectations of his human environment.

Thus, on the one hand, frustrations successfully overcome together by child and mother strengthen the relationship between them and augur a happy outcome to later and more severe trials. On the other hand, lack of success may damage the developing love between child and mother. Then the child will enter into later crises not only with no experience of successful solution of problems, but with bad habits and an inefficient approach, unable to face the implications of growing up and seeking to return to earlier and happier patterns of life.

In Ann's case we have discussed the factors in the first few weeks of life that exposed her both to frustration and to lack of satisfaction. Ann's disturbance of relationship formation was fundamental. Her shrinking, withdrawing reaction, except in the one respect of fighting her mother, pervaded her life. She imbibed not confidence with her mother's milk but anxiety and insecurity, which had poisoned all her relationships since. Even though her recently developed capacity for play with other children suggested that the damage might not be irreparable, her condition had been serious enough to have caused great unhappiness.

Ann's reaction was one of poor adaptation, of clinging to babyhood, in no respect better shown than in her refusal of toilet training. She had little confidence, because the necessary modification of her infantile instinctual life had not been covered by an adequate loving relationship. However, it seemed that the hatred and hostility engendered by the frustrations of the early feeding situation were of no great intensity, and this may have been because of the generally low pitch of intensity of her emotional relationships.

In Ann's case the trouble occurred before the character forming period and her difficulties could scarcely be ascribed to repression of hostility. She was not unable to express aggression; but she needed some degree of confidence in order to do so. Her relationship with her mother was just sufficient to give some base from which her aggressiveness could start.

The paradox of the timid child who is 'hateful' to her mother is classical, and typical of some first year disturbances. Ann's expression of her hatred and hostility to her mother only, was a sign of the confidence she had in her mother's love for her. Ann's mother received the full effect of the troublesome legacy of hate, and was the object of all the worst in Ann's nature.

Unfortunately as every child will discover, actions full of hatred breed hatred and

revenge: a child who acts hatefully may anticipate revenge from his mother. The anticipation of parental revenge will engender guilt in the child which, as conscience develops in later childhood, may develop into guilt at what is felt to be evil and wrong within.

A guilty child may demand reassurance—and Ann later became placatory in her attitude to her father. She also demanded her mother's entire attention, whether by loving or by 'difficult' behaviour. Attention-getting behaviour is often compounded of a need to obtain the visible signs of the mother's continued love, together with hostility and revenge for past evils and wrongs; and, as character develops, of despair and rage at the unsatisfactoriness of the relationship, the child's own inability to be loving and good, and her need to be punished.

So, she 'fights you all the time'. The cardinal feature of Ann's state was that all her human relationships were affected: with her mother she was hostile; with her father docile and placatory; and with the rest of the world, she was shrinking and withdrawing. There was little hope of spontaneous change because Ann not only lacked satisfaction at an instinctual level but, with the growth of character and with moral training, there was danger that her guilt and depression would increase.

With Ann's parents there was equally little prospect of spontaneous improvement. The responsibilities of parenthood interfered with their mode of solution of their personal problems. Inevitably they would be more than normally apprehensive about their responsibilities, so that spontaneity towards each other would get submerged in their urge to bring the child up properly. The mother was suffering a cruel punishment, with a child who fought her; she had the ties and irritations of parenthood without its compensations. The father suffered, too, from his wife's lesser opportunity and inclination to mother him. Worse for them was their sense of failure; they were bad parents in their own estimation. Naturally they fluctuated between indulgence and correction. They did not enjoy their child, nor the child her parents.

This family problem, therefore, had arisen out of its own living forces, through the disturbance of the parents' neurotic solution of their own problems, perpetuated by the impairment of Ann's relationship formation and her resulting difficulties. There was no ground for hope that Ann 'will grow out of it'. All three members of the family needed to find better ways of entering into relationships with other people.

Peter P. (18) 10½ years

The Child Welfare Centre doctor's referral letter commented: 'He seems to have been tired for several years.' The complaints according to the doctor, included poor weight gain, pains behind the knees and in the calves, nervousness, nail-biting, thumb-sucking, and masturbation, which the mother thought caused his weakness. Physical examination revealed nothing abnormal.

Mrs. P. complained most about Peter's finger-sucking. She said: 'He sucks his fingers like an hungry wolf', implying something extremely voracious—an urgent lack in his life. This happened mostly while he was asleep and his aunt had got up ten times the previous night in order to take his fingers out of his mouth. At the same time with his other hand he used to hold his genitals.

The mother also spoke of his restlessness; some nights 'he cries all night for no reason'. He rarely fell asleep before 10 p.m. and used to wake at 5 a.m.

He had wet the bed twice in the previous 3 years. 'He has no nails left' (they were not, in fact, badly bitten). His mother said: 'Really he brings nothing but trouble—but perhaps that is punishment because I love him so much.'

The Family

All four grandparents had come from Cyprus and before retirement and return there, had been engaged in the usual intense small business activities of Cypriots. The father had a café and club, and the mother a dressmaking business over the café. The extended family lived together; Peter shared a bedroom with two maternal aunts who helped in the dressmaking business. This arrangement struck none of them as inconvenient. Other relatives came and went in the house. The father had been in the café business all his life. His small Soho dancing and drinking club involved him in a 14-hour day and he had little time and little to do with the children. Mrs. P. said he was very strict with Peter and afraid of spoiling him. The mother was anxious, excitable, small, dark and voluble, and left a cool impression, being very preoccupied with the dressmaking business.

Helen was born about one year and a half after the parents' marriage. She had never given a moment's trouble in her life. The second child, born 1 year later, died at the age of 14 months. Peter came next, 15 months after the death, and 2½ years later still, another girl was born.

According to the mother, only Peter caused trouble. The family was at least united in its preoccupation with earning a living, and they had little time for the more emotional aspects of family life. It seemed that a child who did not fit in would find little in the family to help him through a difficult patch. Domestically they were cramped through overfilling their house with relatives, but there was no shortage of money.

Mrs. P. was quite well in pregnancy with Peter. She had wanted another boy to make up for the loss of the older boy. Peter's birth was normal but the day after her discharge from hospital on the 14th day the mother was admitted to a fever hospital with post-puerperal fever. Breast feeding was discontinued, and Peter was entrusted to a maternal aunt. When the mother returned 12 days later Peter was having acute feeding difficulties, and she thought he was going to die. When he was 30 days old, he was admitted to hospital where he remained for 6 months. The mother visited regularly once a week. She could not remember why they kept him there so long.

It was not possible to find out what Peter was like on discharge from hospital. Mrs. P. had lost contact with him and she did not know enough about small children to make comparisons. She made no complaints of his behaviour at that time.

At the outbreak of war the mother sent Peter, then 12 months old, with his sister to a residential nursery in Buckinghamshire, where at first she visited every fortnight and later, every month. A year later the nursery was re-evacuated to Somerset and she visited once a month. She thought that he was well and happy in the nursery, but she did not seem to have concerned herself very much. Both children returned home when Peter was 5, but he did not settle, and was disturbed in his behaviour (his mother mentioned thumb-sucking). A few months later she sent him

by himself to a boarding school for a further year. He was not happy there, but his mother thought he was not unhappier than before.

He had mumps at 9, and 6 months later he was hit on the nose by an iron bar and had a very bad black eye.

He said he liked his junior school. His mother tried hard to make him like his lessons and to get him to do extra homework but in spite of this he was very backward. He took the grammar school entrance examination, under age, and failed. His mother then arranged for special coaching at 2 guineas a lesson, and was not unhopeful of his chances of success, as his father knew one of the school managers—thereby demonstrating something other than an English attitude! Mrs. P. was angry with Peter when he was put down a class because a woman teacher could not manage him. Apparently he used to say things to make the others laugh.

His mother was divided between her desire to make him out to be a social success and to represent him as a problem. She said: 'He likes children but doesn't go out to play with them, anyway there aren't any other children in the street. Whenever he plays with other children he always stirs up trouble. He starts all the fights with his sisters; and if they're playing in the garden and there's trouble, he is sure to be at the root of it.' Nevertheless she said that he had not got a temper and could not stand up for himself.

Examination

R.S.B. Intelligence Scale Form L. C.A. 10.8; M.A. 11.2; IQ 108. His vocabulary was below 10 years; Ballard's Addition and Subtraction Test—10.6 years. He was below average in reading, which may have been due to the family's use of Greek in the home. Peter was fluent in Greek and his English was excellent in accent, construction and use, and he had good verbal fluency. His visual memory was poor in the test, the results of which showed a wide scatter. His concentration was excellent; he enjoyed the test and did his best. He was willing to have a try. His responses were very quick and he reacted well to praise. His sense of humour was lively.

He was a stockily built boy with a dark complexion and a solemn, stilted manner at first. He soon warmed up and became quite voluble in the description of his various activities. He was quite composed, having come from school by himself at short notice.

He referred to his failure to get into grammar school and said: 'Thank goodness I can have another shot this year.' He would prefer a day school to a boarding school because he had had more than enough of being away from home already. His only memory of his wartime nursery was of being ill and alone in a room. He talked about his life at home; 'I have three sisters—I mean two sisters. I was counting myself as a sister,' he added with a laugh.

He showed no preference for either parent. He complained of having aches and pains, a stitch in the side and that his legs hurt after being thrown in the baths by two big boys. He made friends; his best friend was of the same age as himself and in the same class. As he described his friend he became enthusiastic and animated. His ambition was to be a commander in the Royal Navy and his sisters could stay at home and help father; he said his mother did not like the idea. He seemed to be a quiet, girlish boy with obsessional trends, pedantic, but with humour.

Mrs. P. was not an understanding mother—tense, anxious and stilted, voluble when relaxed. She worried about Peter's 'weakness and bad nerves'. 'He is not strong enough to concentrate.' He was extremely distractable, could not concentrate for more than a few minutes, did not listen to what was being said at home, and she resented talking to him when his mind was wandering.

He played and quarrelled with his sisters. His mother thought his friends were backward boys and he did not keep them for long. He sucked his thumb noisily, but his mother bandaged it. She now thought she had been mistaken about the masturbation; but characteristically made him wear his pyjamas back to front. She realized that it was not good for him to share a bedroom with two aunts but would not have him sleeping alone downstairs. She was at pains to justify both her past neglect and her present preoccupations on the grounds that life is hard for foreigners trying to make a living in London. She explained that they were so busy that neither parent saw much of the children. She wanted to compensate the children for this neglect as long as this did not interfere with her commitments.

Discussion

Peter's family atmosphere was very different from that of Ann's family in which all the eggs were in one basket, as it were, and in which father, mother and child formed a tightly knit unit, complementary and self sufficient—as far as they went. Peter's family, in contrast, showed many of the values of an extended kinship family structure, but distorted by expatriate stresses.

Much of their trouble arose from the gearing of their family relationships to those of a joint family when the grandparents were 2,000 miles away and two aunts only remained as the rump of the larger group.

It may have been the looseness of joint family relationship, in which a sick child would be looked after by whoever was most suitably placed to do so and not necessarily the mother, that led her to allow Peter to spend his first 6 months in hospital. Similarly, at the outbreak of war, it was natural in such a family that the two tiny children should be evacuated into the grandparental care of the state.

The result was that the mother lost Peter's early childhood and she was so much at sea when he returned at 5 that she had to send him away again for a further year or more. Subsequently, both parents showed a feverish drive to build up the material security of the family, possibly as a compensation for its emotional insecurity.

More recently, the mother had tried to improve the situation, watching Peter carefully, and worrying because 'he cries for no reason', attempting to compensate by excessive attention, for her guilt over past neglect. She worried because he did not fall asleep promptly at 7.30 p.m. and about his 'weakness' supposedly due to masturbation. She gave him 'homework' when none of the others had any, and she spent relatively large sums of money on extra coaching.

Peter's reaction pattern in general was in-turning, and his instinct modification had taken place at a lower pitch of emotional tension than that of Ann who showed a clinging, dependent, self-compensating reaction and was difficult and hostile with her mother. In spite of a bad start Peter showed on the whole, a healthy, integrating type of reaction pattern.

He had suffered an almost total loss of early infantile relationship formation experiences. His first 7 months spent impersonally in hospital left him subdued but

trouble free. Although babyish and retarded in the residential nursery, the company of his sister had probably prevented a more complete withdrawal. She had been well established before going away at 3, and was the one stable and constant influence in his life up to the time he was 5.

The 'low tension' of Peter's emotional relationships was revealed in his 'feeble' approach to life. He followed slowly into each new experience—not embracing life eagerly nor showing initiative or courage. His finger-sucking indicated primitive self compensation, like the alleged masturbation. Nail-biting represented a slight sign of aggression, but turned inwards. His lack of concentration was both retreat into fantasy and a defence against maternal pressure. His buffoonery in class was a humorous defence against social demands.

His lack of definite masculinity, though hardly amounting to femininity was a social handicap. In forming his relationships at an Oedipus level (see pages 267–282) he lacked a father, the normal vehicle of identification, and he also lacked libidinal strength derived from his relationship with his mother. Thus he was a rather girlish boy.

It may be asked why Peter had not gone in for self-compensating stealing in a mild way. With weak ego and super-ego formation and with inadequate satisfactions, stealing and other delinquencies often result. Peter's disturbance of relationship formation was that of a general poverty of affect, with little unresolved aggression and hostility and therefore little motive for delinquency.

When character has formed at 'low tension', on a general background of inadequate satisfactions, anxiety tends to take on somatic forms and is evoked by situations in which aggressive activity is required. Thus, Peter was weak and 'always tired', he had headaches and felt 'washed out'. It was not unlikely that in the future he would suffer from 'effort syndrome' or 'neurasthenia'.

Peter's prognosis was of continued 'low tension' of emotional relationships, that he would do well with modest environmental demands but would lack drive and resilience, and would take refuge in psychosomatic illness when under stress.

AN OUT-TURNING REACTION PATTERN

Tony N. (19) 9 years

The school medical officer reported that Tony was out of control and aggressive with other children in school. He was slower and more backward in school work than his IQ of 87 warranted. The headmaster reported that he was very difficult at school and refused either to work or play like the other children. He was 6 months older than the average age of his special class for backward children, being backward in nearly all classroom subjects. Out of class he was rough, often quarrelsome. His parents took no interest in his school progress.

The problem as seen by his mother was that Tony was never still and always in trouble through quarrelling with other children. His older sister's attempts to boss him always ended in a fight. She felt that his father was too lenient and that Tony had got out of hand, partly because the father would not let her punish him.

Tony lived with his parents and sisters aged 10 and 2 years in a three-bedroomed suburban flat.

The father, aged 36, was a window cleaner who during the war worked on

demolition, after being rejected for military service because of old mastoid trouble. He was a good mixer, was fond of the children and used to bring toys home. The mother said: 'He is a good scholar, a bit short-tempered, though he hasn't hit me all his life. He doesn't like being bothered in the house.' He was the third of eight children, lost his parents early and had no contact with his relations. She said that he did not 'like them at the door', for he considered them to be selfish and sponging.

The mother aged 32, was timid, and intellectually and emotionally limited. She was at a loss with the older children and seemed to wish that children would sit still, be obedient and put their toys away when finished with. She lost her own mother when 13. Her father remarried and placed her in a convent where she was very unhappy, until 16. The family had all been baptized Roman Catholic, but their only religious connection was with a women's meeting belonging to an evangelical mission.

The family atmosphere was casual and haphazard, especially in relation to moral and cultural values, which left its mark on the children. They had no social life and nobody called on them. The mother's unrealism was illustrated by her disappointment when, after the first interview at the clinic, Tony continued to be troublesome.

Mrs. N. recognized Tony's capacity for making friends, but disliked his quarrelsome aggressiveness. 'Tony is hungry-natured.' He went in for scrumping and picking up odds and ends, in contrast with the more successful Maureen who was cheeky but caused no trouble—a 'madam' but reliable, getting on well at school with plenty of friends and interests. She was good to Tony, but he was always calling her names or making scenes so that she was ashamed of him. She tried to teach him to swim, but he was 'up in arms against her'. The father was all for Tony, who, people said, 'is the spit of his father'.

Tony was a wanted baby 12 months after Maureen, born in hospital at term, after an easy pregnancy; birth weight 7 lb. 4 oz.; breast fed. He was a lovely baby and everything was fine for the first 3 months, after which he was taken to hospital with bronchitis. There he contracted measles and was transferred to a fever hospital for 7 weeks before a visit was allowed. His mother said he looked terrible, was thin and his head was bandaged. She was so shocked that she removed him to a children's hospital where his condition of misery and carbuncles caused comment.

After 3 weeks he was sent to a convalescent home and his total absence from home was about 4 months. When he returned, his physical condition was improved but he was sucking his thumb and had done so ever since.

He picked up well, crawled at 11 months, and walked at 15 months. He had been dry ever since his return from the convalescent home. Mrs. N. delayed weaning for she felt that he needed the security of a bottle and final weaning was achieved without difficulty at about 18 months. He had never presented a feeding problem.

At 2, Tony had whooping cough, and at 3, he fell from a bedroom window—it was thought that a boy dared him to jump. When he was 4, he went away with his mother and sister for a few weeks, which was his only separation from his father, after being in hospital.

Tony started school at 4½ years, attended regularly, but was very backward. As a small boy he would go with people easily and do as he was told; he used to help his mother, but now would not. He refused to go to cubs, but liked going with his mother to a women's meeting at a nearby mission church and to the children's

'twilight hour' there. She thought he had been jealous of the baby. He played mainly with Dinky toys and was agitating for a bicycle.

Examination

R.S.B. Intelligence Scale Form L. C.A. 9.0; M.A. 7.10; IQ 87; P.R. 21.5.

His performance ability was at about the same level. He was right handed and left eyed and his motor co-ordination, as shown by skill in manipulation, was not good. His reading tested at the 6-year level. A great deal of mirror writing was noticed, which might suggest a specific reading/writing disability. He was a non-reader as far as the school was concerned.

At the psychological test he was amenable, but without enthusiasm. He was guarded, timid, and maintained a child-teacher relationship. He sustained effort poorly and sometimes seemed not only pleased but also a little surprised at success. Spontaneity was lacking, responses limited and he did not initiate any remarks.

He was a small, sallow, pale child, but he came for a psychiatric interview cheerfully enough and asked questions about the toys. He was a slow starter but gradually his behaviour loosened and he became absorbed in Dinky toys, farm animals and soldiers.

His play was rather secretive, in a sort of huddle in the middle of the table within which the figures were in compact groups, vehicles being laid out in lines. He used toys merely appropriately, the cars in lines, the cows around a feeding trough, with a minimum of movement and showed extremely limited and static imagination. He seemed happy playing and there was no atmosphere of strain, he was enjoying himself in a quiet, subdued way. He used mainly his right hand. His finger nails were badly bitten.

He volunteered nothing, but responded to questions about home and school. He maintained that he liked school and his new teacher. His favourite lesson was 'playing games out in the playground'. His description of his family was: 'Well, there's me Mum and Dad, me two sisters, meself and the cat.' He much preferred the baby, Cathy, to Maureen. He had plenty of friends. He took the doctor into his confidence only to a limited degree.

His mother appeared to be subdued, pleasant to deal with but slow in comprehension. She implied that really there was not very much trouble at home but the school was always complaining. He was always very hungry; 'I've never known him full.' The home was made unhappy by his spitefulness with Maureen. The mother thought that he was jealous of Maureen's competence.

Discussion

There may be some temptation to deem this more a school than a home problem, and the mother lacked discernment of the extent of the trouble at home. There was certainly a great difference between his reported behaviour at school, at home and at the clinic.

The striking quality of this family atmosphere was that the family appeared to be drifting within a secure social environment. There were no special economic or housing difficulties. The parents were sufficiently united for the mother to speak only kindly of the father.

The most important feature of Tony's troubles was the universality of his difficulty

in entering into relationships with other children and adults. He was always hungry, always 'on the ask': and whenever he felt moderately secure he became aggressive. He could not live and let live; he had to interfere, was always in trouble, was always getting involved in fights.

There was no information available of hereditary factors. Tony's parents were unwilling to talk about their own past unhappy childhoods and merely denied the existence of psychological troubles. The father's impersonal upbringing had resulted in a remarkably churlish attitude to his own family. He was mildly indulgent to his children provided they did not bother him when he preferred to be left alone. The mother still resented being sent to a convent after her mother's death.

Their married life lacked depth, they drifted along with little inner warmth of conviction to help them. Their religion was a vague morality, their cultural values were unorganized; they neither enjoyed the present nor lived in hope for the future. Their immaturity was such that they could not appreciate childhood for its own sake, nor know what they wanted their children to grow into, nor how to set about getting it. These parents did not rate highly as objects for children's identification.

Tony's parents were united in their resentment of their own childhood, and it is possible that a major motive for their marriage was to secure from the other the love that had been denied them. Children born to such a marriage would not be very welcome. The father 'can't be bothered with them' and the mother felt inadequate to bring them up, or as she would express it, 'control them'. Her convent memories had caused her to confuse the form with the substance of good behaviour. Her over-evaluation of 'good' behaviour and her fear of spontaneity made her dream wistfully that her children would sit still and be more obedient. When they would not, she was lost.

In spite of the parents' old troubles, all went well with Tony until he disappeared into hospital at 3 months. However unreliable the mother's recollections may be, she was sufficiently upset by his appearance to remove him from hospital, and the children's hospital concerned enough to send him to a convalescent home, though this last may not have been the wisest course to have taken.

At the age of 9 months, Tony was still lying down—a babe in arms, and as Spitz has shown, tiny babies temporarily separated from their mothers show evidence of 'grief'. They lie inertly, take no notice of attention, look the picture of misery. All movements are slowed down, they are not responsive, will not feed, and lose weight. Tony's condition on his return home was suggestively like this.

His mother reacted to his infantile need, by resorting to bottle feeding, which she continued until 18 months. Whether she was ignorant and at a loss; or determined not to miss the pleasure of feeding him in her arms; or lazy and seeking the easy way out, her reaction was evidence that she had not rejected him, even unconsciously.

Though they were shiftless people, somewhat at odds with the world and lacking higher virtues in their domestic life, they were not lacking the basic matter of parent-love; for when the mother prolonged bottle feeding far beyond the usual period, she was spontaneously and unconsciously doing the best possible thing for Tony. His weaning was completed at about 18 months and his subsequent development was patchy. For example, toilet training was established early, but his behaviour was subdued except for the effects of his jealousy of Maureen. It seemed that during the

separation, Tony had lost confidence in the child-mother relationship and had been seeking it ever since. Not being satisfied with results, he was aggressive and bad-tempered. Unlike Ann (17) and Peter (18) who took the blame on themselves and became inhibited, Tony turned outwards to the world in an active hostile way when he was not feeling too threatened to show his aggressiveness.

Tony's hostility pervaded the whole of his activities; all his relationships were poisoned. At home he was constantly in trouble; at school he got satisfaction neither from classwork nor from friendships with the other children. At the clinic, he was grossly insecure and fearful at first. However, unlike Norman (10) Raymond (12) or Muriel (13) who had more profound disturbances and who showed no responsiveness to the environment, Tony's capacity for forming relationships, though impaired, was not absent.

The cardinal feature of the cases of Ann (17), Peter (18), Tony (19) and Simon (20) was their non-specific character. Their difficulties in relationship formation permeated their whole life, but varied in form according to circumstances. In comparison, difficulties that arise later in infancy provoke specific reactions according to the development going on at the time of the disturbance; thus a disturbance originating during weaning may result in difficulties over feeding and the control of aggression but it might not impair the child's capacity for forming loving relationships.

Tony was unreasonably demanding and restless with his contemporaries. There was little give and take. His serious jealousy of his older sister and her attempts to dominate him dated back to his return from the convalescent home when the 2-year-old girl could not tolerate the invasion of a rival who needed special attention from his mother. Their mutual jealousy caused them to miss the experience of growing up together in amity and realizing the advantages as well as the drawbacks of their kinship.

Tony got on with his friends up to a point; then usually his aggressiveness provoked quarrels. He had one fairly stable friend, but most of his friendships went bad. He could not be generous, nor satisfied; but was always looking for he knew not what; but he was neither a bully nor a coward.

The one exception was that he loved his 2-year-old sister, and was gentle, kindly and considerate with her. Moral pressure, family expectations and natural inclinations will all combine in favour of sibling love; and hatred is a source of guilt to the hating parties. She was not a rival, he did not want the kind of love she demanded and he instinctively responded to the appeal of the tiny. His tiresome quarrel with his older sister impelled him to lavish his love on the baby, for good boys love their sisters, or so the cultural pattern demands. Thus Tony's hatred became concentrated on his older sister and his love on the younger. This love was no sign of grace and regeneracy, but rather, was an unstable solution to an emotional conflict. It was a symptom of neurosis.

It might be asked, how much of Tony's trouble was due to an unsympathetic school, his rather low intelligence and his crossed lateral reading and writing difficulty? Non-readers of 9 tend to suffer increasingly from unfavourable comparison with other children; but at least a quarter of his class were duller than he, and his indifferent intelligence should have caused no particular difficulties. His bad behaviour was not directed against the teachers, but was a mixture of spitefulness, aggressiveness and excessive timidity. For example, he was frightened of the water,

and would not let his sister splash him or help him to learn to swim. It was the social situation rather than the learning situation that troubled him at school.

The scientific evidence about mirror writing, and eye and hand dominance is conflicting; but in any case, Tony's troubles were apparent long before school days. Crossed laterality may possibly increase the difficulty of learning for the child of indifferent intelligence. This may be serious when the child who has failed to gain satisfaction from his home life equally fails in school. School can be a great consoler or, conversely, the last straw if lack of success there deprives the child of satisfaction and a happy outlet for his energies. If corporate life at school becomes a trial to a child, anxiety and disturbed behaviour will result, and the child's attitude to new things, including learning, will be tainted by his fears. He will be backward in class and, like Tony, may be a rough, quarrelsome and unpleasant customer in the playground.

The Outlook

On theoretical grounds it seems possible that Tony and his family could be helped by simple psychotherapy to break the vicious circle in which Tony, by his aggressive search for love, destroyed his chances of securing it. In manipulating the therapeutic relationship, the therapist would show respect and consideration, and Tony would gain some appreciation without having to struggle for it. He could behave badly without forfeiting his growing relationship. In due course interpretations by simple remarks and actions could be made to Tony, to show him the significance of his behaviour, while supporting him in any anxiety which this might engender.

Concurrently the psychiatric social worker would help the mother to aim at more consistent goals in the family way of life; at the replacement of confusion and anxiety by confidence and peace of mind. A limited improvement in family morale could be hoped for.

Simon L. (20) 4.2 years

In the case of Simon, the really significant information about the mother's attitude and early experiences took more than a year to piece together.

Simon was referred by an M. & C.W. medical officer because he was intensely jealous, would cling to his mother, and try to get her apart from the baby. His behaviour varied from general fury, tempers, or hurting the baby or his mother when she was attending to the baby, to hurting himself 'accidentally'. 'Mummy is the only one who will do for him. She thinks she is the cause of his difficulties, and when I suggested the possibility of Child Guidance for Simon she asked whether it would help if she had some, too', wrote the doctor.

Mrs. L.'s own account of her problems speaks for itself. 'He always seems to be at war with me. He is much worse with me than with anybody else. I get upset myself and shake the daylight out of him. I get quite mad and am afraid of what I may do to him. He screams when thwarted and will not stop.' She got upset because he would say 'I'll shoot you'. She said that she had read psychological books and thought of herself as seeking perfection, and was upset at what had happened. Her husband thought things were not so bad with Simon, but he did not see what went on when he was not there. She first consulted the Welfare Centre when Simon was 3½.

Simon was planned, after 4 years of marriage, when the parents obtained a flat of their own. The pregnancy was disturbed by much coughing and the baby was turned several times. Hospital confinement, 5 weeks late. The foetal head was held up at the brim of the pelvis and dropped suddenly, the baby was in a state of white asphyxia and extremely shocked. He was a 'lazy feeder'—used to fall asleep while feeding, if not shaken and slapped. Mrs. L. felt extremely frustrated, and discovered to her horror that she got angry with him. She became very anxious and wept that she could get so angry with the little baby whom she had wanted so much. She put him on a strict routine of eight 3-hourly feeds each day. She had little sleep and much worry; she would cry if he did not take a feed well.

At the christening party, the relatives said how puny he was, and put heavy pressure upon her with their differing advice. She could not accept even a simple suggestion of her mother-in-law's to reduce routine and be more flexible.

After a very quiet start Simon's crying increased and by 3 months he had become excitable, lively and noisy. The doctor advised keeping him quiet and the maternal grandmother came to help.

The situation began to improve. Teething started at 7 months and he screamed tremendously when his bicuspid came through. He sat up at 6 months, crawled at 8 months and said 'Dad'. Walked alone at 16 months, when he also swallowed a bottle-full of thyroid tablets. His mother regarded this as an act of naughtiness. A stomach pump was used at the hospital and Simon fought and screamed. At this time also, he ruined a family holiday by screaming the whole time. At 18 months his mother left him in the care of his grandmother for 2 months because she could not stand his screaming.

Of toilet training his mother said: 'I was wrong with him. I used to sit him on a chamber and he would sit there and do nothing. He would sit there making noises and smile at me'. Then she would get in a rage and shake him. He was very destructive, broke his toys, and walked in his sleep.

Simon was jealous of his younger sister, and aggressive and protective with her in turn, but his jealousy did not appear as an important factor in the family life. Rita was born when Simon was 3 years old, and was a perfect baby. She compensated the mother for her trouble with Simon and more and more engaged the father's attention. Later on in treatment, when Simon's symptoms were less, Mrs. L. complained that Rita was very like Simon. It was evident that this out-turning, demanding, never-resting behaviour permeated all his relationships, and it revealed a basic difficulty in relationship formation.

Mr. L. had been partially disabled through childhood poliomyelitis but although he appeared delicate, he was not hampered in his work as a quantity surveyor.

Mrs. L. was extremely full of guilt. The P.S.W. remarked: 'rarely have I seen a more apologetic person, more willing and eager to say it was all her fault.' She was pretty, always well-dressed in a dumpy sort of way. It was immediately clear that she was preoccupied with obstetrics, fascinated by the process of birth and obsessed with sex.

This family was so dominated by the legacy of feeling from the mother's own childhood experiences that an account of these needs to be given.

Mrs. L. was extremely ambivalent towards her own mother. Her father deserted when she was about 8, and some 20 years later Mrs. L. discovered that her parents'

marriage had been bigamous. In fact it seemed more probable that the story of bigamy covered a more casual union. Though she represented her mother as the dupe of her father, she had been very attached to him.

When he went away they passed into a dreary phase. The grandmother was working as an hotel receptionist and Mrs. L. lived mainly with her own grandmother. At 10 she was sent to a convent, where she was extremely unhappy. She spoke virulently about her treatment by the nuns. 'With sheer, planned cruelty,' she said bitterly, 'they used to set traps to catch the children and beat them with wire hair-brushes until the blood came.' At 14 she went as under-nursemaid to a rich family but after 6 months her mother sent her to a convent in France for further finishing.

She was not so miserable in the French convent. She recollected that on her arrival the Mother Superior took one look at her and sent her off to the hairdresser: in sharp contrast with the British convent. She was not really happy and at 17 she became hysterical after appendicectomy, in a dramatic situation. 'I was a bit down—all the French chattering got me down and I had mental hysteria.' She added: 'These nuns were kinder to me than the English ones, they sent me home.' She worked as a nursemaid, and then as a shop assistant.

When Mrs. L. was about 12, her mother married again, at the age of 44, a man who was only 30. What followed appeared more like fantasy than fact, but she never varied her story over more than 5 years.

She had learnt about masturbation from other girls at the convent, but this had been solitary, and with great guilt. At about 12, she suffered from a sharp religious conflict over masturbation. At 14, when she was on holiday at home her mother went away for a fortnight and left her with her 32-year-old stepfather. Under the guise of sex education he asked her to masturbate him 'for her mother's sake'. This happened several times and she voluntarily slept in his bed, because she was frightened of sleeping alone. He told her to wear two pairs of knickers under her nightdress because he could not be quite certain of what he might do when he was asleep.

The process was repeated when she returned from France, at 17, but with great distaste on her part. He told her that she would soon experience a change of feeling and enjoy herself. She became frightened and told her mother. There was a big family row, but after a short period of embarrassment things returned to normal. Her stepfather was unrepentant and continued to talk to Mrs. L. about sex: that a girl 'ought to satisfy the excitement that she aroused in her boy-friend.' He egged her on to excite her boy-friends sexually, in order to prove her power over them. When things started getting dangerous, she used to deal with the situation by masturbation. Then she met her future husband, who was deformed, in contrast with her usual 'he-man' type of friend. She appears to have married during a sharp attack of sexual guilt, and was bitterly ashamed of her husband's deformity.

After marriage Mrs. L. was sexually frigid; after Simon's birth she did not want more children and she distrusted contraceptives. Rita was an accident. Sexual intercourse was usually limited to mutual masturbation, which was distasteful to her though occasionally satisfactory. When her husband made approaches she felt 'like a lamb being led to the slaughter'.

It was inescapable that much of her anxiety over Simon was sexual anxiety. In describing her fears of doing him serious harm while in a rage, she several times described how she would 'shake the daylight out of him'. Free associating in treat-

ment, later, she related this 'shake the daylight' to her masturbation of her stepfather. She had a fantasy, of controlling a dangerous male by 'shaking the daylight out of him' and this had become mixed up with her anxiety over Simon's temper tantrums.

Mrs. L.'s state of mind was illustrated by an incident that happened during her treatment. Her stepfather was sitting in the chair by the window, when she went into the room to get some cutlery. She caught a glimpse of him in a mirror and was 'rooted to the ground with horror' at what she saw. Then she saw that he was sharpening a pencil. She had had a flash-back to her 14-year-old experiences of his sitting in the room exposing his penis, waiting for her to take notice.

Examination

The psychologist found that Simon was friendly and composed, provided his mother stayed with him. Merrill Palmer Intelligence Scale, C.A. 4.1; M.A. 4.1.

He would not enter the psychiatrist's consulting-room alone, but after a few moments allowed his mother to leave. He played with the toys eagerly, smiling, looking at the doctor. He was communicative and announced firmly that he liked his Daddy best.

His play was active but not rich in fantasy. His movements were clumsy and at times, perhaps, over-controlled. It was considered that he was of markedly out-turning temperament, but suffering from an insecurity reaction dating back to a poor maternal relationship in early infancy. He appeared to be unable to control his unresolved aggressiveness effectively, vacillating between over-control and temper tantrum.

At a later interview Mrs. L. summed up her own condition by saying that she was morbidly interested in sex and always thinking about it. She would not visit her friend next door during the day, because her husband was on night duty and she might interrupt them 'at it'. She could not bear to have couples staying with her because of thinking of 'it'. She made these revelations with no sign of distress in the recital.

It was decided to treat the mother, while looking after Simon's interests in school. The mother attended faithfully for about one year and at first was entirely concerned with recital of her sexual difficulties. It seemed that whatever sex pleasure she was getting in life was obtained by talking about her troubles. Gradually, however, with interpretation of her fantasies to her, she produced frightening dreams and other signs of anxiety, which had to be worked through. From start to finish, Simon was not often mentioned by the mother.

Discussion

It was clear that the mother's unhappy childhood cast a blight over this family and her guilty adolescent recollections had driven her into marriage with a man of whom she was ashamed; and she hated herself for her shame. Fortunately his behaviour under consistently trying circumstances was usually admirable, and his relationship with Simon prevented the latter developing even more intense anxiety.

It may be that the mother's state of tension contributed to the difficulties of pregnancy and labour, for Simon was shocked at birth. Like Ann T.'s (17) mother, Mrs. L.'s troubles started at once, but the latter was most shocked by her own tumul-

tuous feelings. Mrs. L. might possibly have found relief from her guilt in giving herself to her baby but was frustrated in this by Simon's lethargy.

Her attitude to maternity was poisoned by sexual guilt derived from her convent experiences and later from her stepfather. In her hatred of the nuns who had contributed (however unwittingly or unavoidably) to the misery of her childhood, she had indignantly rejected the positive aspects of their religion, while retaining their unabsolvable sense of guilt, so that she was denied religious comfort. This, it may be noted, is an example of a not uncommon unfortunate outcome of the replacement of an unsatisfactory early childhood home life by a convent upbringing that is both impersonal and moralistic.

Sex guilt pursued Mrs. L. when nursing her baby, and consumed her with rage and frustration at the child who 'would not' feed. She was too guilty to cuddle him, for she had a horror of body contact. Instead, she fed him 3-hourly day and night, thereby giving herself maximum punishment by loss of sleep, misery, frustration, and guilt over her feelings; and Simon, maximum frustration of bodily needs, and denial of comfort. Each mealtime was a nightmare of nearly uncontrollable rage for the mother and of unresolved tension for Simon.

It appears to have taken 3 months for Simon to recover from his birth difficulties and reveal himself as an active, out-turning boy, able to form relationships. Thereafter his main reaction pattern was one of out-turning compensation. He was active, demanding, jealous and insecure, but his compensating relationships with his father and grandparents were threatened by the birth of Rita and his father's attachment to her. His mother's jealousy of the father's relationship with Simon also led to recriminations.

Mrs. L.'s violent feelings were constantly being touched off by some association with her sexual guiltiness, which also caused projection of her feelings on to others. Thus she blamed the nuns for her unhappiness, her stepfather for her unwise marriage, and Simon for not feeding, but for this last she was also bitterly ashamed of herself.

The thyroid tablet swallowing episode was illuminating. The poisonous tablets were left within reach, with the bottle top unscrewed. This, of course, in her eyes was Simon's own fault, and his terror of the stomach pump was wilful naughtiness. It was her violent rage, also, at his lack of response to toilet training that started off her impulse 'to shake the daylight out of him'.

Perhaps Mrs. L. in her guiltiness did not do justice to her handling of Simon; perhaps father and grandparents supplied a balance for the mother's ambivalence. Apart from a certain over-control and some panic temper tantrums, and if Mrs. L. was not too unreasonable, Simon's extraverted friendliness carried him through, except that when under special stress he would show various tics—notably blinking.

During an uneven course of treatment, Mrs. L.'s anxious fears of her violence to Simon subsided and her sexual guilt abated. Simon was less difficult and life was quieter for about 5 years, except when Rita had some minor disturbances at about 4. Later, when Mrs. L.'s mother and stepfather came for a prolonged stay, she was able to ride out the storm with a little help.

Though not seriously disturbed Simon seemed permanently affected. He was touchy, jealous, demanding and given to making scenes at home; at times nasty to Rita, and his grandparents, to whom he was really very attached. At school, like-

wise, though gregarious and friendly, Simon was isolated by his jealous demands and the scenes he created. In every aspect of his life his aggressiveness was only partly inhibited and he lacked concentration. He was never really happy.

FURTHER EXAMPLES OF FIRST-YEAR DIFFICULTIES

The four cases (17)–(20) illustrate a fair range of the problems common among children with early infantile difficulties. These children were not as fundamentally disorientated in human relationships as the group of cases described previously (10)–(16). It is generally true that the compensatory reactions of 'first-year' children rather than the real cause of the difficulty are responsible for the bulk of the disturbance of behaviour.

We have seen that these 'first-year' problems are characterized by a general disturbance of behaviour. Insecurity and anxiety are usually obvious, whether in the excitable restlessness of the out-turning child; or the timid, even depressed, withdrawal of the in-turning child; or a state of inhibition. Among other children, a variety of predominantly somatic reactions may be met with. The cases which follow (21)–(33) will amplify the illustration of the commoner reaction types.

A GENERAL INSECURITY REACTION AFFECTING SUBSEQUENT DEVELOPMENT

Cecil C. (21) 7.3 years

Cecil's behaviour at home exasperated his mother. He was cheeky, provoking and dreamy; for example, when told to wash his face he might smear it with dirt, 'for a joke'. At school he would say silly things in order to get attention or would do his writing so small that no one could read it. He tore up a school book, but immediately owned up. He had been treated for tics and bedwetting, and from 5 months of age had had attacks every 2–3 months of high temperature, constipation, distended abdomen, sometimes abdominal pain and vomiting.

Cecil lived with his father, mother and grown-up sister and brother in a tiny 2-bedroomed flat. During his brother's absence on National Service Cecil slept in a single bed in his parents' bedroom. His father was a hairdresser aged 59, a chronic sufferer from duodenal ulcer. His mother was aged 43, anxious and obsessional, with a great pressure of talk. She had had an anxious childhood with considerable hardship and had worked for most of her life.

During pregnancy the mother suffered much from vomiting, abdominal pains and faintness. Confinement was easy, but a large head naevus started the mother's worries, which were augmented by the air raids. The naevus was removed. Cecil was breast fed for 9 months, but he did not seem robust. He screamed at night, was cross and difficult to wean.

At 5 months the attacks of cyclical vomiting added to his mother's worries. During his second year, Cecil took badly to each new development and was restless, demanding and clinging. Flying bombs, when Cecil was 3, completed his mother's discomfiture. She sent Cecil to the house of a stranger, 100 miles away, had a 'nervous breakdown' and did not see Cecil for 12 months.

On his return home he did not recognize his mother, and his behaviour was disturbed for some time. Some months later, when the foster mother came on a visit, he was hostile to her. He disliked school at 5, and was sent to another, where he was happier, but continued to be difficult.

His mother emphasized his extremes of mood, restlessness and destructiveness; but he was basically obedient, perhaps over-good. He was not demonstrative, but liked his mother within sight when he was at home. He was friendly, but unable to keep friends.

With his elderly father Cecil kept up a fantasy game in which his father was the captain and he the bo'sun. He spent much of his time reading and writing, a favourite occupation being copying passages from the Prayer Book.

Cecil was of average intelligence; with good verbal but only moderate reasoning ability. Under test, his span of attention was short, concentration and persistence poor. He showed good critical sense and enjoyed praise.

At examination he was rather girlish looking, with good manners, was clean and neatly dressed. After politely asking permission he devoted himself to bathing and dressing dolls, ignoring the constructional toys.

Between examination and the commencement of psychotherapy he accidentally broke his arm, but was not upset. Under treatment he gradually lost his politeness and over-control. Cecil first became whimsical, with babyish 'faerie' fantasies becoming to a child of 4 years. He regressed still further, to a mud pie, water-spashing level. Then, with great anxiety he mimed aggressive gestures against the therapist and then his mother; and later started 'showing off' before his mother. During this phase of treatment it was not easy to hold his outraged mother's confidence. One could almost hear her telling her friends: 'Treatment is only making him worse.' After some months, however, she realized how much better he was able to cope with life; and this was awkward, too, for she did not altogether wish him to grow up.

Comment

Later knowledge of this family confirmed the first conclusion that Cecil's basic difficulty was insecurity dating back to the suckling period. A third pregnancy, 12 years after the last, heavy bombing and other wartime anxieties, combined to upset Mrs. C. and she could not give her baby the security and warm body nurture that he needed. Yet her love was greater than her rejection and it stimulated without satisfying him. He formed a reasonably strong basis of relationship; but though it was insufficient to stand strain, it was enough to provoke him to seek for more. Thus his pattern of demanding behaviour developed. Up to the age of about 2 years, his mother coped almost well enough—neither completely satisfying nor frustrating him. It often happens that mothers who reject their babies because of adverse circumstances rather than immaturity will give their helpless infant enough love to enable his relationships to develop, but not enough to give him security.

When the child becomes mobile, the anxious, ambivalent and perhaps over-compensating mother cannot trust her child and enable him to grow towards independence. But since she does not satisfy his needs, he will not remain easy and compliant. An in-turning child will tend to withdraw, but an out-turning child, like Cecil, will become demanding, and will seek for himself the satisfaction he

lacks. Unfortunately, his regressed and babyish, clamouring and insatiable behaviour will almost certainly alienate the sympathy of the adults.

Such children will tend to get into difficulty at each subsequent stage. Cecil fortuitously suffered prolonged separation from his mother when 3, but had a good substitute mother. Reunion with his parents at 4 left a legacy of an unresolved Oedipus situation. Rivalry with his father led to identification with his mother, increased his anxiety and guilt and impaired his developing masculinity (see Chapter 12). He was uncertain of his control of aggressive feelings, and was nervous and touchy in any competitive situation. Under stress he broke down into temper tantrums and was always excitable, with tics and habit spasms. Characteristically he was violent only at home where he was safe from major harm. He was subdued at school. He could not resist the temptation to seek sympathy by babyish behaviour, as if he were saying: 'Look at me, I'm only very little but very sweet.' Unfortunately for him his whimsicality was encouraged by his elderly father, which further impaired Cecil's judgment, so that he played the fool with visitors to the home and, in due course, with teachers and the other children at school. Unfortunately the laughter there was not that of fond parents, and in this way buffoons are created.

Charles S. (22) 9 years

Charles was referred by a school medical officer because of day and night wetting, but Charles's mother was far more concerned with the tension between Charles and his father. The latter nagged Charles, calling him 'stupid, crazy, mad, crackers'. He would push Charles out of the way, rather than ask him to move. She said: 'Meal-times are hell; he tells Charles off in such a degrading way.' If Charles showed his mother affection his father would call him 'cissy'; if he made a fuss of the baby his father would tell him not to breathe germs on him. The father would not answer Charles's questions.

Charles's school did not find him difficult: 'He is rather young for his age, apt to be dreamy and needs constant encouragement.' He was seriously backward in arithmetic.

It appeared that Charles had incurred a disability during the first year of life that rendered him incapable of adjusting to later strains, but that the cause of the trouble originated in the strains of the parents' own childhood.

The 35-year-old father's childhood had been marred by bitter parental quarrels. He had been on a diet for many years for a duodenal ulcer which had partially responded to operation. He was irritable during his periodical returns to dieting. He had a resentful, jealous, nature but, apart from his behaviour over Charles, was not difficult to live with. He was an anxious, obsessional, worrying person, who two generations earlier might have illustrated Gilbert's:

*Very delectable,
Highly respectable,
Threepenny bus young man.*

He was a successful company secretary even if he always fought his immediate superior. It was clear that he nagged Charles because of anxiety for him.

Charles's mother, aged 33, was a well turned-out woman who had never quite

emancipated herself from her overwhelmingly large family. She complained that her husband and son were completely dependent on her, but this reassured her.

Charles's early years were disturbed by war-time conditions. Pregnancy and birth were normal, but the father was on war service and Charles and his mother followed him to a series of furnished rooms. They were miserably unsettled and the father was too preoccupied to notice Charles.

Charles was a very cross baby and Mrs. S. was at her wits' end to keep him quiet for the landlady's sake. Days were disturbed; he was not a good feeder, for he interrupted himself by screaming and was unsatisfied. He hated his cot or pram, and nights were appalling.

Mrs. S. lost confidence, she delayed weaning until past 12 months and then abruptly took him off the breast, and she recounted how he beat her with his fists. During his second year Charles's behaviour became quieter and more controlled. All his new developments were late, and he never achieved bladder control. At 18 months, the father was posted abroad for 3½ years, and Mrs. S. and Charles lived with the maternal grandparents, three aunts and an uncle. Charles was overwhelmed by relatives and was teased a great deal. His mother worked and Charles went to a day nursery where he was reported to be timid and unadventurous. At 4½ they lived for some months with a maternal aunt who was houseproud, and the strain of keeping Charles under control made the mother ill. When the father came home, they all returned to live under crowded conditions in the maternal grandparents' home, and had a place of their own only 3 months before the younger child was born.

Charles went to school at 5, passively, but a few months later, at the time that his father came home, he had a passing phase of unhappiness at school and of sleeping badly. He seems to have withdrawn and become babyish for a time. Later he was passive and easy at school; friendly with the other children, but with little capacity for effort. He also passively received his baby brother at 6.

Upon examination at the age of 9.1 years his IQ was 105. (R.S.B. Form L.) Good verbal fluency, average vocabulary, poor visual memory and drawing ability. He was, perhaps, too aware of his shortcomings. Reading, one year in advance of mental age; Number, 2-3 years retarded. His bright appearance, good manners and verbal fluency gave a misleading impression of high intelligence.

Underneath Charles's good looks he had a strained anxious expression and red-rimmed eyes, as if he cried a lot. He could not be persuaded to play with the toys at the first interview but, although tense, was eager to talk. He was guarded and uninformative about things which really mattered to him, and was intensely ashamed of his bedwetting.

Comment

It appeared that Charles's troubles arose from his parents' personalities. Apart from her attitude to sex, Mrs. S. was warm, but unconfident and resented the father's attitude to Charles. Her sexual coldness possibly left her uncertain in handling her baby physically, and she had not been sufficiently united with her husband to function for both during his prolonged absence.

Mr. S.'s anxious rigidity caused him to flounder in his family relationships. It had been too much for him to come home to find an ill wife and a regressed, inhibited

son of 5 years. His reaction of anxiety had made him intolerant, increased the child's inhibitions and earned his wife's resentment.

Charles was treated by a combination of psychotherapy, counselling for the mother and remedial teaching in arithmetic. The result over a period of about 18 months was satisfactory, and there was every prospect of Charles making an adequate readjustment.

Charles resembled Cecil C. (21) but differed from him in that Charles had a first-year insecurity derived from his mother's anxiety and efforts to keep him quiet in furnished lodgings. Typically, she continued breast feeding for 12 months, then weaned him abruptly. Charles's rage at this passed gradually into inhibition, hidden somewhat by his out-turning temperament. Thus he appeared passive, friendly and easy but lacking in adaptiveness. His babyish general development was also a result of his father's absence during the oedipal period, which retarded the evolution of his masculinity. Mr. S.'s anxious reaction to Charles's 'cissyness' made matters worse. His school backwardness was also due to passivity and inhibition.

This case illustrates again the all-pervading quality of first-year troubles and the vicious circle of parental anxiety reactions which they establish. The father's uncertainty in handling increased the boy's difficulties, and the former's disaffection led him to canalize his affections on to his baby daughter, greatly adding to the adverse influences in the home. However, Charles's subsequent readjustment was a sign of his comparatively good basic relationship with his mother.

PRIMARY FEEDING ANXIETY

Janet S. (23) 4.2 years

Janet's mother was full of complaints. Janet was never happy, screamed a great deal; was defiant, self-willed, disobedient, played adults off against each other, and was very unfriendly. When her mother left her with a day minder in order to go to work, Janet would kick and tear at the door, scream and throw things: 'Anyone would think she was being murdered.' She created scenes with her mother whenever anyone else was present.

Janet said 'wicked things' such as: 'I'm going to be bad today'; 'I'm going to upset you today'; and to her mother's man-friend: 'Mummy and I don't want you, we want to go away and be together.'

Janet was illegitimate, her mother had moved home seven times during pregnancy, being miserably unhappy. Confinement was normal. Janet went to a day nursery from 3 weeks. She screamed excessively at night. At 3 months she went to hospital for 3 months with gastro-enteritis. She continued with the day nursery until 4 years of age. Her motor development was consistently 2-3 months late. She had much ill health and had orthopaedic treatment for foot trouble.

Later, her appetite improved, but nights continued disturbed. Her aim was not to be left alone in the bedroom. At the infants' school to which she was admitted early, she was described as 'a very trying child'.

Her mother said: 'Janet is a very vigorous child, never still, very intelligent and can be good.' 'She is affectionate to me but to no one else.' 'She is very destructive with her toys, breaks them even before they get out of the shop, she pulls bits off and doesn't play much with them.'

The mother seemed depressed, and spoke of her own unhappy home life. She had struggled to live independently, but when Janet was 12 months old had had to go back to her own mother, and Janet had played up her grandmother. The mother's attempts to get married were all nipped in the bud by Janet's jealous, demanding behaviour.

Psychiatric examination proved difficult. At first Janet would not allow her mother out of her sight, but after a preliminary negative phase, she co-operated, perhaps overactively. She was above average in intelligence: C.A. 4.0; Merrill Palmer M.A. 4.9.

Janet flatly rejected treatment by a man therapist, apparently identifying him with her mother's man-friend who threatened her precarious adjustment at home. She started promisingly with a woman therapist but, unfortunately, changing social circumstances terminated treatment.

Comment

Janet's mother was depressed at her birth and Janet was placed in a day nursery at 3 weeks, and was in hospital from 3 until 6 months, so that her success in forming relationships speaks well for the quality of care of the nursery and the hospital, and also for her mother's loving qualities. Even after 4 years of extremely difficult behaviour that had made life well-nigh impossible, her mother was still motivated to subordinate everything to Janet's interests, no doubt partly out of guilty restitution but also out of considerable loving warmth.

Janet's out-turning temperament revealed everything that was going on in her. The crux of the case was an early infantile insecurity reaction which, owing to the considerable strength of interpersonal relationships involved, resulted in an intensely demanding reaction which was spoiling all Janet's relationships in every part of her life—typical of a first-year disturbance.

Miriam G. (24) 6.9 years

Miriam was a poor physical specimen who was so thin that her upper arm could be encircled by the thumb and index finger, even through an overcoat. She had a chronic upper respiratory tract infection, with constitutional disturbances following a collapsed middle lobe of the right lung at 4½. She failed to gain weight and was not progressing at school.

Miriam's father was a policeman with a history of duodenal ulcer. Her mother was a good-looking young woman, much preoccupied with gynaecological troubles. Sex had always been a bugbear to her, never pleasurable and, since her only pregnancy, intolerable. She was anxious because she did not believe her husband's assurances that he did not want another child, and had been alarmed by warnings that she must keep her husband satisfied, or she would lose him. She was herself an only child, who had been greatly attached to her own father. Apart from the sexual difficulties the marriage was sound, thanks to the husband's conscientiousness which, however, added to the pressure upon Miriam.

The mother was uneasy during pregnancy, which had been planned; she regarded childbearing as woman's great burden. The confinement was normal but she had complained of backaches and tiredness ever since. She had no milk, but artificial feeding was carried out with meticulous care. Miriam generally lacked vigour, but

nothing dramatic occurred. Feeding was always a trouble, even after weaning; her mother fussed her with unnecessary prohibitions, overdressed her and overwhelmed her with anxious care. Miriam's only child contacts were, occasionally, with two girl cousins. She was passive, cried easily and was upset by other children. Her convent school report stated: 'Miriam is very backward, mainly due to absence and ill health, as well as a feeling of her own inferiority. . . . With careful handling and much encouragement she will make progress. She lacks powers of concentration. She shows normal intelligence. Her behaviour is excellent.'

Upon psychological examination: R.S.B. Form L. C.A. 6.9; M.A. 7.0; IQ 104; P.R. 60. Reading was retarded, she confused some letters and recognized only a few words. She responded to praise and encouragement. Seguin Form Board M.A. 6-7. Healy Picture Completion Test I (which interested her) M.A. 10. She was remarkably passive, but responded to encouragement under test. The unusual spectacle of a flood of water falling past the window provoked no comment and only very slight interest.

During psychiatric examination Miriam was demure and did what was asked, passively. However, when invited, she settled with no hesitation to play with the dolls. She tidily tucked them up in bed and then looked round for something else. She arranged some animal figures in groups, with very little movement indeed, except occasionally glancing at the examiner with a half-smile. She placed two lions in a pen with some sheep, and when questioned, said: 'They're chasing each other.' She did not develop the situation imaginatively.

Miriam became more animated and half an hour later she was relatively lively, laughing and had a flushed face. She did not want to leave and even mildly resisted her mother.

At this interview the mother complained of breathlessness going up two flights of stairs. She felt that Miriam was improving and was taking lunches at school, but eating very little at home. She ascribed all Miriam's troubles to her poor feeding. Miriam weighed only 37 lb.

Comment

Miriam was neither particularly in-turning nor out-turning. Though anxiety made her withdraw, given encouragement she quickly came out of her shell and she had lately successfully taken to school dinners. There was a clear trend towards improvement.

The key to this family's difficulties was in the personalities of the parents. The father was an obsessively over-conscientious man. His seriously father-fixated wife was sexually frigid and hypochondriacal. When Miriam was tiny her mother failed to give her genuine primitive body comfort and Miriam lacked zest for life. The mother's uncertainty had provoked an inhibited reaction in Miriam and had prolonged the feeding difficulties. She adjusted with difficulty in every aspect of her life and remained lacking in zest, retarded and timid.

With such psychosomatic parents, the best chance of improving Miriam's outlook appeared to lie through stabilizing the parents' attitudes. Miriam could adapt when given the chance, but clearly her parents had smothered her prospects of spontaneous improvement.

The practical difficulties of treating psychosomatic parents under the guise of

helping the child are very considerable. This situation is one of the most difficult in the field of child guidance.

FIRST-YEAR INSECURITY

Next we come to consider two cases of children with markedly out-turning temperaments, who suffered breaks and disturbances of their relationship formation during the first year of life. They are both typical of a not uncommon difficulty.

OUT-TURNING INSECURITY

David B. (25) 4.2 years

David was referred by a local M. & C.W. medical officer, with a complaint of bad dreams. The doctor was concerned about his disturbed domestic background and poor physical condition. David was underweight, and had chronically infected tonsils and adenoids.

David was an only child, living with his parents in a 2-roomed flat. He insisted upon having his cot pushed right up against his parents' bed. The parents complained of David's night terrors every night, and sometimes 4 or 5 times, in which he did not recognize his mother and was terrified of someone under his bed. His mother blamed herself for smacking him nightly for a fortnight when he was 2, for being wet, and also for parental arguments in front of him.

Mr. B. was a boyish-looking, cheerful and friendly man of 28. He had had a dominating mother. He had served in the army for 3 years in India, where he had met his wife. When demobilized at 24 he worked as a salesman. He was hearty, gregarious, and keen on sport. He was also the pianist in a small dance band, which he enjoyed very much. This took him out at night and his friendships with other women caused constant quarrelling.

Mrs. B. was 26 and pretty. Her complicated family history concealed her Anglo-Indian origin. She was the eldest of five children, deserted by her parents and brought up strictly and cruelly by an unwilling grandmother. She longed to give her own child the sort of childhood that she herself had missed.

She contracted a runaway marriage in order to get away and make a fresh start. Both families had disapproved, but various members of her own family coming to London had relieved her loneliness a little. The paternal grandmother was critical, but the mother felt that she had not done enough for David's health when she had looked after him.

Marriage relationships were discordant; but both parents had realized the bad effects of quarrelling upon David. The mother was bored and lonely, and had taken up singing in order to join the father's dance band, but this had not worked out well. She worked intermittently as a clerk. Both parents thought they would divorce, sooner or later.

Personal History

David was born about 18 months after the marriage. Pregnancy was unplanned, but trouble free; labour normal; birth weight 6½ lb. David was a 'lazy' baby and con-

tinued difficult to feed after being put on a bottle at 3 months, and when solids were introduced. At 2 years he weighed 27 lb. and at 4 years only 29 lb. All developmental landmarks were normal. Pot training started from birth, but at 2 years he used to wake every night wet and dirty and screaming. He was clean and dry from this time on.

Until 18 months he lived with his parents in the paternal grandparents' house and there were constant family quarrels. When they moved to their own flat, the mother worked and parked David by day with a married woman, for 4 months, then successively with two registered foster-mothers for 2 months, and for 6 months a woman looked after him in the flat by day and then he was placed in a day nursery for 3 months. Then the mother left the father for 1 month, leaving David who was extremely upset, by day with her temporary landlady.

The parents reunited and his grandparents took David on condition that his mother did not visit for 3 months. The grandfather, of whom David was very fond, died a few weeks later. After 1 year, and 2 months before examination, David returned home against his father's wishes.

His mother thought that David was highly strung, excitable, gregarious and friendly, but unused to children of his own age. He must always be doing something and played active games with cars and trains for hours. He loved playing cricket with his father. He was undemonstrative and resisted caresses.

Examination

Merrill Palmer Intelligence Scale C.A. 4.2; M.A. 4.4.; R.S.B. Form L. M.A. 4.2. He was quick with his hands and had good control; speech well developed. He showed insecurity in the face of difficulty, he was inclined to say 'I'm not big enough'; but when encouraged he quickly transferred his feeling, scolding the material and saying: 'I'm not having that.'

He was a small, red-faced, thin, lively, noisy child. In a free situation he showed extremely quick movements and talked incessantly, with a broad grin. He verbalized everything and spoke all his thoughts out loud, was intensely distractable and settled to nothing. He littered the floor with discarded toys, shouted and banged about, asked innumerable questions without waiting for answers. The slightest event, such as a car hooter or a movement changed his activity. He was slightly dependent on the doctor but showed no concept of any relationship with him, nor of why he was there.

The parents seen (separately) on this occasion both talked of their marital difficulties rather than about David, though they spoke of his night terrors and poor appetite. They were both frank about the marriage difficulty, and recognized the unpropitious circumstance of the soldier abroad marrying a local girl. The mother was lonely and felt unsupported. The father appeared to have been punishing his wife for trapping him into marriage, but he responded to her charm and was proud of her good looks. Both parties separately suggested a truce if they could be assured that this might help David.

And in this way the matter was resolved. Both parents had further separate talks with the psychiatric social worker. The first improvement was quieter nights with David and then more harmony and companionship between the parents. Eleven months later the mother reported no further difficulties, David had taken tonsillect-

tomy easily, was enjoying school; but feeding was still indifferent. She added: 'My husband and I have got over our own troubles and have quite settled down. I am back at work and am quite happy and settled in my own mind. Things are fine altogether and I think I can safely say my husband feels the same way as I do. We are most grateful to you for your help.'

Comment

Although at first sight the family difficulties seemed to be at their peak, it is possible that the parents were already beginning to resolve their troubles and only needed encouragement to complete their rehabilitation. They had made the mistake, commonly seen in the adjustment difficulties of post-war couples with poor accommodation, of trying to patch things up without the child and then taking their disturbed child back, being overwhelmed by the ensuing troubles. The parents had been comparative strangers at marriage, the immature father shirked the responsibilities of fatherhood and did not know how to share his extraverted bachelor pursuits. The mother was disappointed that the streets of London were not paved with gold. But both had the capacity for warm, loving relationships.

David had an extremely out-turning temperament which, with his lack of confidence in basic relationships, made him very restless, excitable and distractable. His mother reported that he was a lazy baby who fed poorly and without interest. This may have been the subjective memory of a distracted mother living under great difficulties with her mother-in-law. But she evidently felt that she was not close to him and he must have lacked experience of body comfort. In later infancy his out-turning qualities led him into preoccupation with objects—toys and movement rather than with human relationships. Several changes of day time care, prolonged separation from his mother and the loss of his grandfather—the only person with whom he had a close relationship—cumulatively increased his lack of confidence in people. His passivity in feeding developed into inhibition at the time of weaning, and the appearance of nightmares could have been evidence of inhibiting aggressivity. He compensated partly by intense activity and interest in inanimate objects, and partly by his combination of over-dependence with poverty of relationship formation. Typically of a first-year difficulty, David's troubles pervaded every side of his life with great intensity. His strongly developed mechanisms of compensation enabled him to pick up more secure threads of relationship with his parents when the emotional climate improved at home.

Robert L. (26) 6.4 years

Robert's general practitioner wrote: 'His habit of fidgeting is irritating his family and his teachers almost beyond endurance. I am sure that somebody could help this family to peace and harmony.'

The family consisted of parents, Robert, and Sally aged 3½; they were reasonably united and had high standards of behaviour and child care. They shared a large suburban house amicably with friends.

The father was a senior local government clerical officer, who apart from a prolonged bout of anxiety following upon a wartime head injury, had been in good health, and who was of congenial personality and fond of his children.

The mother was humourless, rarely smiled and had a solemn and miserable ex-

pression. She blamed herself for the difficulties that centred round Robert. Before marriage she had been a Civil Service clerk and had enjoyed the work. Her childhood was happy and uneventful.

Sally was an easy, friendly child, a great solace to her mother after Robert.

Robert's Personal History

The mother wanted children, but grudged giving up her work; pregnancy uneventful, birth at term with normal labour. Birth weight 4 lb.; her lack of experience made her very anxious indeed. Breast fed, supplemented for 5 months.

As a baby he was 'very good'; as a toddler 'he was very wearing; so agile and quick, if you took your eye off him he was gone. Here one minute, gone the next; he saw no obstacles.'

For his mother 'goodness' meant no trouble and a minimum of anxiety. So long as Robert had no will of his own he was 'good'.

He was forward in development and easy to train. At 2½ years he spent 10 days in hospital with cervical adenitis. At 2¾ years he scalded his leg and was upset for a while. He was 'always ailing' with colds and other minor illnesses. He was a finicky feeder, and without a lot of sleep was bad tempered and very trying.

He liked school, made friends and brought them home. He was well behaved in class and naughty in the playground.

At home things were different. He had always been aggressive, she said, never cuddly as a baby, and only affectionate in competition with his sister of whom he was at first very jealous. He had wanted a baby, but on return home from staying with his grandmother he had become 'listless, whiny, lost his appetite and was unmanageable'. For 2 months he had urinated only in the garden. On the whole he was fond of his sister, and she idolized him, but sometimes he was nasty.

Now, he was active and unimaginative, enjoyed journeys, was interested in things and observant. He enjoyed model making and had elaborate ideas. With his mother he was disobedient, rude, argumentative and intolerant of correction. Away from her, his behaviour was perfect but with her, he put her to shame; there was great tension between them. She unfolded a long tale of worry, irritation, guilt and anxiety; for she knew she ought to be nice to Robert and blamed herself for all the tension. She would go to meet him from school because he seemed to want it and would force herself to look pleased when she saw him. He would constantly interrupt her housework to get her to admire something he was doing and she would resist going for she was houseproud, whereupon he would whine. She would then force herself to be gracious and bought herself 5 minutes' peace, until the next interruption.

Examination

Robert was tense and timid, with half-controlled restless movements and facial tics. He yawned during tests and his fingers were badly bitten. R.S.B. Form L., high average intelligence, arithmetic slightly below average.

His movements were quick and jerky, but purposeful. He settled at once to play with cars and other small toys in a strictly practical way, becoming absorbed in play. With added confidence his movements became quicker and more impulsive, his tics increased but he remained on his guard. His rigidity and inhibition con-

trusted with his naturally out-turning temperament, but he was anxious and guilty. It appeared that he could be aggressive only to his mother.

Treatment seemed imperative, and Robert attended for play therapy while the P.S.W. saw his mother. The first change in Robert was a marked increase in tics, which the mother found hard to bear. For 5 weekly visits he remained unapproachable, absorbed in play and humourless. At the sixth he was livelier and talked.

At the seventh visit he did not play but was hostile and aggressive, and hit the therapist, which was interpreted verbally and in play. Then he became playful, almost humorous. He was ill the next week and at the following visit was dependent but remote, bored and something of a buffoon. Then, over a period of 2 months, he was disturbed and hostile, but showed some original fantasy. After 5 months he was warmer, more playful, less driven to be annoying at the clinic, but verbally very hostile at home.

Three months later he was being wildly excited, though friendly at the clinic and, to some extent, at home, too. Ultimately, after about 14 months treatment, his mother found that, though livelier and noisier than previously, he was not so continually unpleasant and impossible either at home or at school, and was making less trouble in the playground.

Comment

This family provides an example of difficulty and unhappiness among ordinary worthy people, anxious only to do the best for their children, whose troubles were derived as much from their virtues as from their faults. No doubt Mrs. L. had enjoyed her job and had not wanted to give it up, but to infer that she was a self-centred, unmaternal, career woman would be to ignore the social context.

During the war there was a strong pressure of public opinion on young married women to take employment. Also, Mr. L. had been restricted to home service, for psychiatric reasons. To become pregnant in such circumstances would have been slightly shameful to a woman of Mrs. L.'s personality, and her ambivalence towards the baby, though regrettable, could be understood.

Mrs. L.'s conscious memories of her own childhood were of unalloyed happiness. Yet her anxious and humourless personality could only have developed through over-control of feelings and repression of both hostility and of unpleasant memories. She approached motherhood with guilt and anxiety and she failed to give her baby peace, satisfaction and serenity in the early months.

While he was still helpless she thought of him as 'good'. From the moment he showed individuality and capacity to move, her rigidity of control began to break down. Weaning left him finicky but dissatisfied; 'goodness' gave place to ceaseless movement. Then the 'tug-of-war' began; Robert seeking, demanding, striving; his mother attempting to regain control by restrictive measures without understanding of either his needs or his capacities.

His demands upon his mother, in search of satisfaction, increased both her anxiety and her need to control him by restriction, and established perhaps the most common vicious circle in child-mother relationships. Robert's behaviour was complicated by a good deal of guilty punishment seeking; and Mrs. L. on her part guiltily solaced herself with the beloved and easy Sally, which greatly inflamed Robert's jealousy.

In Robert's case there was some exception to the common principle that first-year disturbances permeate every aspect of life. His relationship with his father, though not very intimate, was fairly positive. Mr. L. was warm, if ineffectual; though he was goaded by his wife into a punitive attitude towards Robert that he did not really feel, and toward Sally, too, in a futile effort not to be unfair to Robert. Robert gained enough from his father to make partially satisfactory relationships with contemporaries and he had much that was positive, too, with Sally, in spite of not unjustified jealousy.

Robert's great load of anxiety and guilt had caused his imperfect control of his strong emotions and had led to inhibition, to lack of confidence and to a tendency to panic. He would freeze in unfamiliar situations and at school had neither the heart nor the confidence to make consistent efforts.

In spite of his bad attitude to his mother and hers to him, he had more confidence in her than in anyone else and could afford to reveal his hostility to her, alone. Only, in so doing he went far to destroy her capacity to remedy the situation. This was the crux of the therapeutic situation.

IN-TURNING INSECURITY

Graham B. (27) 5.9 years

Graham was first referred because he was 'uncontrollable' at home, backward at school, solitary and friendless. Mental deficiency was suspected.

The family was living in 3 rooms in a 'down-town' area of London. The father had been a milk roundsman but was serving in the army at that time. Six months later he was posted abroad for one year. He was an easy-going, quiet man not much concerned with his children while they were young.

The mother was vivacious, warm and motherly, but seemed rather to overwhelm her children. She worked at a half-time job and a neighbour minded the youngest child.

Pauline was 3 years older than Graham, a pretty, lively child, her mother's favourite and not interested in her brothers. Timothy was 3 years younger than Graham.

Pregnancy and birth normal, breast fed 9 months; an easy, happy baby. Pot training started at birth and he co-operated easily. At 9 months he went to hospital with whooping cough for 5 weeks and, after the pre-war fashion, was not visited by his mother. When he came home he began having tempers and being generally miserable.

Weaning was completed in hospital and feeding was no problem, but he flew into a temper when sat on the pot. He became clean at about 2½ but bedwetting had continued intermittently up to the present. He walked at 18 months but with a staggering gait for several months.

At 18 months he went into hospital for 5 weeks with measles. Thereafter all his development was slow. He had only just begun to talk at 3 when he returned to hospital for 6 weeks with scarlet fever. Six weeks later he was in hospital again for 3 weeks with chickenpox, during which time Timothy was born. He was then in such poor condition that his doctor sent him to a children's hospital for 6 weeks and then to a country convalescent home for 6 months, where his mother visited monthly.

He started school aged 4½ (quite usual in wartime London when mothers were working). He settled well except for long absences due to intercurrent illnesses, but he learned nothing. Soon Mrs. B. was receiving complaints of his stubbornness, disobedience, violent tempers and truanting after dinner. Although his mother was at home in the early afternoon, he would hang on to lorries and travel long distances. Several times he had to be fetched back from places many miles distant.

At home he was restless, bored and aimless. During violent scenes over his stubborn disobedience he threw things about and destroyed toys. He showed affection only for Timothy. Mrs. B. felt at her wits' end.

Curiously, he could sleep at any hour and often dropped off to sleep in a chair when he came in from school, or play. He was generally ready for bed by 6 p.m. and slept through to 7.30 a.m. This type of sleep rhythm is rare among English children, except occasionally among in-turning children with weak interpersonal relationships.

Often he woke screaming in the night and could only be pacified by his mother getting into bed with him, which she hated doing.

Examination

Merrill Palmer Scale: C.A. 5.9.; M.A. 6.3. He appeared to be competent but insecure. Psychiatric examination brought to light the strength of his imperfectly controlled aggressive feelings, his fear of his feelings and his jealousy of his sister.

Physical examination revealed a blurred first heart sound in the mitral area, and according to the practice of that time (1944), he was treated by the school clinic as 'subacute rheumatism', and exercise and games were restricted. He was also recommended for psychotherapy.

Fate intervened in the shape of flying bombs and the three children were evacuated without their mother, so that the cardiac precautions were not enforced. Eventually the father was demobilized and the whole family came back to London.

Four years later Graham (10 years) was sent back to the clinic by a Juvenile Court; he was becoming progressively more difficult. One year previously he had been placed on probation on a charge of breaking and entering and larceny. He was truanting from school, and 10 months later was charged with stealing oranges and while on remand at home, truanted again, broke into a workman's hut and stole a fountain pen.

Mrs. B. appeared to be a warm person, but exerting much emotional pressure on her children. She complained that Graham had become 'wooden' since his return from evacuation. He was very reserved and defensive and was especially sensitive and resistive to blame. 'You cannot penetrate under his skin.' Only when visiting his old evacuation billet did he seem to unfreeze.

Though family relations seemed good, Graham had never got close to his father who, when the offences were committed, had been in hospital quite seriously ill.

Retested on the R.S.B. Form L., C.A. 10.3; M.A. 10.10; IQ 106. He was remote and apathetic in manner, with a long scatter due to poor immediate memory. Vocabulary was restricted and he was 2 years retarded in basic school subjects.

At psychiatric examination he was defensive, seemingly hostile and merely said 'yes' or 'no' in a husky voice; but then expanded on why he did not like school. Nothing much came out, but he became relatively friendly. The ice was broken

when he found a hen's egg, which he had forgotten, in his pocket. (There was food rationing, and eggs were precious.)

Graham attended for treatment faithfully for 14 months and kept in touch for a further 18 months. He started slowly with remote, quiet play; but after a few weeks showed intense physical activity, though in silence. His mother then reported that things were 'ever so much better at home', he was cheerful, willing, and friendly and was not truanting. She was convinced that he was cured, but of this there was no indication at the clinic.

After about 4 months of treatment, his behaviour changed at home and he became bitter and difficult, especially with his father. Truanting started again and there was another stealing episode. For several months Graham was balanced on a knife edge of committal to an approved school. His mother was terribly distressed but co-operated loyally. He was tense at the clinic but gradually began to talk about his difficulties and became warmer. Eventually the family barque sailed into calmer waters after a further burst of truanting, stealing and hostile behaviour, and at 13 the probation order was cancelled. Five years later he was doing well as a National Serviceman.

Comment

The essence of Graham's case was that wartime difficulties prevented his mother from compensating him for repeated separations from her, and the absence of the father on military service further upset his character development.

After 9 months' satisfaction in breast feeding his sudden removal to hospital and hurried weaning caused Graham to withdraw, 'having tempers and being generally miserable'. Mrs. B. then rather overwhelmed him and the tantrums persisted. Further hospitalization and intermittent maternal pressure completed Graham's withdrawal and aroused his hostility. At the age of 5.9 years such was his attitude to the adult world that he was 'uncontrollable at home' and thought at school to be possibly mentally defective.

Paradoxically, evacuation saved the situation and Graham achieved poise and moderate happiness in a comparatively impersonal atmosphere. Upon return home, his mother's intensity revived his old hostility and his relationship with his father was too weak for Graham adequately to control his feelings. At school he had sufficient relationships with undesirable types of boy to get involved in the kind of delinquency that arises from poor interpersonal relationships stimulated by hostility. This, at least, was a sign of the existence of emotional relationships.

The aim of treatment was to enable Graham to gain control of his unmastered feelings, and to give his mother enough confidence not to overwhelm him with her anxiety. It was necessary also to hold off the anxieties of a well-meaning legal administration puzzled by Graham's up till then intractable delinquency in an apparently good home.

Daphne R. (28) 10 years

The presenting problems were bedwetting, diurnal frequency of micturition and jealousy of the older sister.

This family, father, mother and girls of 14 and 10 years, lived quietly in a 'prefab' in North London. The father was a factory storekeeper, home-loving but un-

sociable, and who liked to be with the children. He discouraged visitors, prevented his wife from working and even disliked her undertaking baby minding. The mother, who superficially was stolid and slow, was in fact tense, driving and voluble.

The second pregnancy was difficult, Daphne was born 1 month after the outbreak of war, the mother was alarmed at Mr. R.'s impending recall as a regular army reservist and was frightened to sleep on her own. Birth, 7 weeks early; weight 4 lb. Mrs. R. found Daphne 'a little terror'. Early feeding was difficult and the father's first impression of Daphne at 6 months was that she was a very poor specimen.

At 6 months Daphne was in hospital for 1 week, with pneumonia. At 10 months she fell off the table and was 3 days in hospital with concussion. Two weeks later they were bombed out, but unhurt. Daphne and Jean (then nearly 5) stayed with their grandmother for 4 months; Daphne developed bad impetigo. Mrs. R. blamed the grandmother and brought her back to a London hospital where she remained for 7 months. Upon discharge home at 22 months Daphne was very subdued, and backward in development.

A year later she was still highly nervous and in every respect other than toilet cleanliness (a legacy of hospital), she was retarded and babyish.

She relapsed into bedwetting when the father was demobilized, when she was 6. 'He has a shocking, wicked temper' the mother said, 'and yells at the children.' Since that time bedwetting had remained intermittent, up to 2 or 3 weeks dry, on one occasion 6 weeks, then up to 5 nights wet in succession.

Evidently, family relationships were bad. The mother was voluble and aggressive, and the father churlish.

At school Mrs. R. thought that Daphne was a 'little rip, very lively and jolly'. Her teachers thought her a mild problem because of 'poor school work and unsettled behaviour, lack of concentration and memory lapses'. With the other children she was talkative and seemed quite popular, friendly by nature.

Examination

R.S.B. Intelligence Scale Form L. IQ 102; the test result was unremarkable.

At psychiatric examination Daphne's anxiety was the most serious feature. Psychotherapy was recommended, but the family was not ready and treatment failed after a number of missed appointments.

One year later when Daphne was 11.3 years, the school social worker persuaded Mrs. R. to bring Daphne back to hospital. Day-time wetting was worse and night wetting unchanged. Her school backwardness was becoming an acute problem. Mrs. R. complained that Daphne had bad acne of the face, blushed readily and occasionally stammered. She said: 'She makes herself sick with jealousy over Jean; she falls out with all her friends and has no close ones.'

Daphne was a white-faced, depressed-looking girl with only slight acne. In sharp contrast with the voluble aggressiveness of her mother, she looked unhappy, was withdrawn and tongue-tied. She managed to indicate that she did not wish to pass into a grammar school.

Comment

It was concluded that Daphne's withdrawn, in-turning, inhibited condition was

aggravated by her mother's dominance and pressure of anxiety. The mother's quite lively sense of humour, that Daphne had inherited to some extent, slightly redeemed the effects of the father's difficult and rigid personality and sergeant-major attitude within the family. Mr. R.'s jealousy of his relatives set the pattern for bitter sibling rivalry between the children.

Though the presenting symptom dated only from her sixth year, when Mr. R. returned from war service, Daphne's difficulty could be traced to her first year, when her mother was anxious about the outbreak of war and the father's recall to the army. The mother was scared of her responsibilities for her delicate, premature baby. The disturbances were considerable: two short periods in hospital, within 3 months; then, almost immediately bombing out and separation from mother for 4 months; then 7 months in hospital and discharge, 'very subdued', at 22 months.

At the end of her second year, Daphne was seriously regressed, with only tenuous personal relationships. The toilet cleanliness that was established in hospital, by a nurse, was gained with little affective concomitant, little drive to remain clean for mother's sake and no gain in self-respect.

The father's return home aroused tension; Daphne retreated into babyhood, she lost her dry habits and further impaired her poor self-respect. She adjusted neither to home nor school, where she was very backward in spite of average intelligence. However, she was friendly by nature and did not incur hostility, she showed a spark of humour and her basic attitudes to other people were positive. Though she showed a typical first-year disturbance in every aspect of life, it was, relatively, not catastrophic and her eventual response to therapy was favourable.

RESTLESS AND INHIBITING REACTION

Douglas C. (29) 3 years

Douglas was referred by the general practitioner as a highly strung child with attacks of asthma.

Douglas had been adopted at birth and was the illegitimate child of Mrs. C.'s younger sister who lived in a self-contained flat in the same house. This unusual arrangement appeared to cause no difficulty and the natural mother was shortly to be married. Mr. and Mrs. C. had a daughter, Gwen, aged 15.

The adoptive father was a maintenance engineer, a good-natured man, fond of Douglas. The adoptive mother, though more like a grandmother, was motherly, placid, unobtrusive but loved the boy. Sometimes she 'hollered at him' and he would be upset. She had never nursed or cuddled Douglas on the principle that it 'would not be right for a boy'. Douglas got on well with Gwen.

The natural mother disclosed the pregnancy only at 7 months, when her sister promised to adopt the baby. Birth and infancy, normal, except that breast feeding was stopped abruptly at 10 days. There were no feeding difficulties, but Douglas was a crying baby and, for the first 3 months, nights were very disturbed. After that he settled down, developed well and was cheerful and easy, except that his attacks of asthma began at about 3 months, with 'peculiar attacks of going red all over, which usually followed a head cold'. Later, slight attacks of breathlessness had developed roughly once a month, diminishing in the last few months. He had always had slight catarrh.

He had no fear of the dark, but slept in his adoptive parents' room because Mrs. C. liked to watch out for his attacks at night. He occasionally wetted his bed, in phases.

Mrs. C. thought Douglas was a normal child, though she wondered if he were not 'too grown up' for his age. He was never naughty, amused himself easily, and could stick up for himself with other children. He was friendly with others and open natured. From Mrs. C.'s attitude it seemed that she might be treating him as a much older child.

On his first visit to the clinic Douglas would not settle in the consulting-room by himself, he raided the toy cupboard and returned to his mother outside. Then she came in too, and he played with the toys, taking little notice of the adults. He was pale-faced, but active and looked healthy. He played normally with a model train and with dolls' furniture, and was placid, perhaps a little inhibited. Mrs. C. thought that things were better on the whole, but though his attacks were less frequent, the breathlessness was more severe. He was restless at home during the day and nervous and imaginative; e.g. since the butcher had told him that a goose was a dead Indian he had refused all poultry. He was not demonstrative.

Mrs. C. and Douglas attended infrequently for counselling during the next 2 years. He became quite at home at the hospital and although dour, was friendly with everyone. His natural mother married and moved away; she was very undemanding and behaved like a fond aunt, bringing him little presents. Under advice Mrs. C. managed to treat Douglas with more demonstrativeness, quite well on the whole. She worried that Douglas had not been told of his adoption, but until his natural mother agreed to tell her husband she felt bound to silence.

When Douglas was 7½ Mrs. C. reported the occurrence of nightmares, which she ascribed to trouble at school. He disliked his headmistress and it was discovered that he had truanted for 2 weeks. The headmistress was unfriendly and, according to Mrs. C., said: 'You haven't heard the last of this Master C.' Douglas's nightmares occurred several times a week but transfer to a junior school where he liked both the headmaster and his class teacher resolved this situation.

The asthma had ceased but he still occasionally wetted the bed. He tended to worry and was easily put out by other children's tales or by frustration.

Douglas was well grown and quite fat, though pale-faced; distinctly over-controlled in his movements, inhibited and rather in-turning.

R.S.B. Form L. C.A. 8.1.; M.A. 8.4; IQ 103. Schonell Graded Reading Age 6.7 years.

Since things seemed to be on the up-grade again, reassurance was given and a follow-up visit arranged 6 months later, at which Mrs. C. felt that there were no outstanding problems.

Comment

Douglas was showing an inhibited, but restless reaction to first-year insecurity. Probably the so-called asthma during infancy was due to allergy and his breathlessness was secondary to congestion of the upper respiratory tract. It was not until Douglas had become more active that the asthma showed true spasmodic qualities. Lack of bodily comforting during the toddler period seemed to have increased his inhibition and in-turning qualities. He got along fairly well as long as things went

smoothly, but reacted to quite minor difficulties by inhibition, so that his anxiety tended to appear in the form of nightmares and in minor bodily symptoms. The ultimate prognosis seemed to be good.

UNFAVOURABLE REACTION TO SUDDEN WEANING

A BACKWARD AND BABYISH REACTION

Caroline N. (30) 7.4 years

The main problems with Caroline were, no progress at school and difficulties at home—shouting and screaming if crossed.

Caroline lived with her mother and father, Robert 10, and Peter 4½, in a small semi-detached suburban house. At school she was backward, would not concentrate and get on with her work. She had been back kept in the infants' school for an extra term.

The father was a builders' cost clerk, but had been a Warrant Officer in the Royal Engineers, and had lived mainly away from home, until Caroline was 3. He was a nervous, 'highly strung' man, with a great deal of inferiority feeling. He said of his own childhood that he was 'the weakling of the litter', and used this as a reason for not punishing his own children. He had a humorous turn of mind; in describing how his black sheep brother had settled down at last, he said: 'After all you should learn sense by the time you are 50.' After losing a job through irresponsibility, this brother had 'not so much waited for something to turn up as waited for somebody to turn something up for him'.

The mother was 10 years younger than her husband; a quiet and placid person whom the boys resembled, while Caroline took after her father. Her coolness was to some extent put on, but her feeling of hostility to Caroline was fairly obvious. Though Robert was a tease and provoked many of the constant rows with Caroline, it was she who annoyed them by her shouting. Peter presented no problem, and Mrs. N. remarked that it was a pity one could not start one's family with the third child.

Pregnancy and birth were normal: birth weight 7 lb. 2 oz. Caroline was contented and put on weight well for 3 months, until some loss of weight caused transference to bottle feeding. Being wartime, the mother resolved to retain the bottle as long as possible but at 9 months lost her nerve and introduced cup and spoon feeding suddenly. Caroline's reaction was violent and extremely hostile. She refused food and screamed, knocking the spoon out of her mother's hand and getting into terrible rages. The mother was patient and good-humoured and the storm gradually subsided. Caroline started gaining weight once more. However, she continued to be imperious and brooked frustration badly, attempting to bash her way through difficulties by sheer violence.

At 2¼ years, the mother had jaundice and Caroline stayed with her grandmother. At 2½, Peter was born and Caroline was clinging and demanding, attempting to get exclusive attention. She was still wet at night. At 3, the father came home to live and she rejected him violently. At 4, she was in hospital for 6 weeks with scarlet fever, was visited once a week, but at first only through a glass screen. When she came home, she relapsed into bedwetting, was extremely babyish and demanding, selfish and quarrelsome. The storm gradually passed off, but when she

went to school at 5, once again she became touchy, screaming and demanding.

Examination

R.S.B. Form L. C.A. 7.3; M.A. 9.8; IQ 133. Reading Age (Burt) 6.2 years. Caroline was most insecure during the test and did not use her ability unless she was encouraged. She was easily cast down by failure.

In appearance she was dark and anxious looking. Her first reaction was unfriendly but she responded to a sympathetic approach. When greeted she drew to her mother's side as if to refuse to be separated, but said in a calm voice: 'I don't want to take the doll with me.' She went demurely into the consulting-room but she did not play, preferring to stand still and look round the room, and talk. She asked innumerable questions about things, what other children came there, whether there were other playrooms and so on. It seemed that her pressure of talk served to keep the conversation off subjects in which she was emotionally involved.

Comment

Caroline was highly intelligent and her poor results in school were mainly due to her anxiety and inability to make an effort. Her markedly out-turning temperament was to some extent masked by her inhibition. Her difficulties, apparently, were set off by abrupt weaning, and her violent aggression and regression had reappeared at every later family crisis. Whenever frustrated at home she became extremely babyish and attempted to scream her way through the difficulty. At school, where emotional relationships were cooler and feelings weaker, her inhibition predominated, and she was backward and not very noticeable. Certainly her teachers had no idea that she was such a 'bad' child at home.

Caroline responded well to psychotherapy; her schoolwork improved and she could be cheerful and aggressive at home without being hostile. Her mother, with the P.S.W.'s help, became more understanding of her need for warmth in emotional relationships. The father continued to be anxious and prone to psychosomatic illness. Caroline showed reasonable capacity to accept frustration, without violent regressive behaviour.

TENSION AND ANXIETY

Harry D. (31) 9.9 years

Harry was referred from the Pædiatric Department; there were no physical difficulties but his mother was worried by the continuation of head-banging, which had started as shaking the cot while a baby. He would bang his head on the pillow rhythmically and grunt for 20 minutes, most nights on going to bed. He was worse if tired or cross and 'takes it out of his bed'. Lately he had twice stolen about £1 from his mother and bought sweets and cinema tickets. He had always loved money and used to spend the change when sent on errands. He did not appear upset when found out.

Harry lived in 2 rooms with his father and mother and Susan aged 5. For 2 years the father had come home only every third weekend.

There had been a threatened miscarriage at 3 months. Labour was prolonged. Harry was a very active baby. 'He never kept still but was always peering around

him.' He refused cuddling. He was breast fed and had always bolted his food. At 6 months Mrs. D. went into hospital for one night, and Harry was weaned abruptly and sent to a residential nursery for a few days. This experience had no immediate effect on his development. He walked at 10 months.

The mother was careful over toilet training and said that he was 'quite marvellous'; no soiling after 6 weeks and no nappies after 12 months. At 2 years 10 months, when fetched home from hospital after tonsillectomy, he was sitting quietly in his cot and said 'Hullo, mummy', in a very controlled way. He remained subdued and cried a great deal for some weeks. 'It was almost as if he thought it was our fault he had been in hospital.' He was 'a bit of a mummy's boy' at this time. When he was 4, Susan was born and Harry became destructive at home. He enjoyed school and would leave the house at 8 a.m. if allowed to.

The father was a railway foreman, with a history of anxiety and peptic ulcers. He worried because he was sure that the head-banging would do Harry harm. The mother was aged 42 and was equally a worrier.

Harry was terrified by dogs, even puppies, thunder, tube trains, and amusements like Punch and Judy shows. He worried if the train was held up or the bus did not come. He easily took offence, blamed others, was touchy and sensitive to correction and failure. He never seemed really happy, was soon bored, did not appreciate treats and could never amuse himself. He made no close friends. He liked sport but could not bear to be beaten. He enjoyed television and also quite liked going to Cubs and Sunday School. He was jealous and resentful of Susan: 'He takes it out of her and fights to the last lap.'

Examination

R.S.B. Form L. C.A. 9.9.; M.A 11.2; IQ 115. His tenseness prevented the full use of his intelligence.

He was tall for his age, a thin, red-faced boy with a shy manner. He was very promptly obedient and was, perhaps, too good. He said he was happy at school, and his ambition in life was to be a diesel engine driver. He said, unconvincingly, that he got on all right with Susan.

He said that he could stop the head-banging when he liked, but did not know why he always started again. He did not think it hurt him. While talking he busied himself intensely with toy animals, which could have represented an escape from having to answer questions. He arranged the animals into very meticulous patterns.

The parents created an impression of being careful, perhaps over-careful.

Treatment was recommended, but the family decided to move near the father's work. Mrs. D. felt that she needed help, that Harry was precocious and his friends 'rather spivvy types'. She welcomed the re-establishment of the family life with misgiving, rationalizing her doubts by saying that they were moving to a sleepy country place and that 'London has everything for children'. She also dreaded a change of school.

Comment

Harry had a markedly out-turning temperament, and abrupt weaning and some days' separation from his mother had provoked an active, demanding response which his mother treated rigidly and strictly. He then became inhibited and for a while was

an over-good, obsessively clean child. Hospitalization at 3 undermined his precarious adjustment, and Susan's birth a year later reactivated his insecurity. Much of his aggression was projected into fears of thunderstorms, dogs and so forth, and his self-compensation took the form of stealing.

His persistent head-banging was a survival of infantile auto-eroticism that had long since lost its intensity, remaining as a habit that he did not particularly enjoy but found that he could not stop.

ADAPTATION DIFFICULTIES

Hugh A. (32) 4½ years

Hugh was referred to the Pædiatric Department because of slow weight gain. The pædiatrician wrote: 'He refused to be examined and acted in the consulting-room as a film tough guy. This caused his mother to break down and weep, which had not the slightest effect on the child.'

The mother was voluble in her complaints. Hugh was cheeky and defiant, especially in public. 'It makes us feel ashamed and it quite ruined our holiday this summer. He had no reason to cheek us. It was as if he was getting at us and there was no reason for it. His father is very good to him and plays with him a lot, and we take him out a great deal.' He slept badly, got into his parents' bed every night at about midnight, and had never been persuaded to return to his own bed. His sleep was restless and he tossed and mumbled to himself. 'He is just not interested in food', but the general practitioner had never taken his feeding difficulties seriously enough to satisfy the mother.

Hugh was an only child. They had lived in one room until he was 3, and since then in a 2-roomed flat. Mrs. A. resented the communal life of the flats and would not let Hugh play in the courtyard.

The father was aged 27, an accounts clerk, a quick-tempered and moody man, who suffered from the interrupted nights. He was inclined to be sharp with Hugh and to blame the mother for Hugh's troubles. While she was in hospital he said, 'Hugh is O.K., so it must be you.' Hugh disliked his paternal grandmother.

The mother was also 27, pretty and well-dressed, but quiet and depressed-sounding, with an air of indecision. She was very revealing of her feelings about herself, most self-critical and plagued with feelings of failure. She thought that the whole family inclined to be soft and submissive. She wondered if anyone could do anything for Hugh: 'I don't want to waste your time.'

Personal History

Pregnancy and birth were normal; breast feeding supplemented with the bottle. Things went very badly; he cried practically the whole time between meals, except between 6 p.m. and 10 p.m. She remembered long days 'peeling potatoes with one hand and holding baby with the other'. She felt very worn and tired. She abandoned breast feeding at 6 weeks and at 3 months took him to the casualty department of the hospital, quite late one night. She was somewhat reassured by the pædiatrician saying that he was 'a lovely specimen'.

At 4 months, mixed feeding was advised but 'Hugh didn't like it' so she abandoned the attempt. In the second year Hugh slept better but the parents often sat

with him in the dark and in silence. He continued to wake three or four times a night. At 12 months the father took Hugh to the paternal grandparents for 2 weeks and the mother had 'a lovely rest'. Bottle feeding continued until 2 and then stopped suddenly except for a bedtime bottle. When she discontinued this last suddenly, he lost weight. Throughout the toddler period he never slept during the day and could not tolerate being left in the pram or cot; even while she went to the w.c. 'he screamed the roof down'.

He was forward in development. When he was 3, the family was rehoused and he started coming into his parents' room at midnight. At 3½ the mother was in hospital for 2 weeks with appendicitis. The father said that Hugh was 'fine'. He went to a nursery class for 2 months and 'loved it from the first day, class teacher said he was the only one who did not cry'. When he was transferred to the infants' department he became tense, and worried about going.

Mrs. A. said that Hugh could amuse himself quite well, liked doing puzzles and was happy playing cowboys and Indians by himself. He was very active and restless but his 'tough guy' was an act to cover his nervousness. 'He has always been sort of aggressive, and very stubborn and will never give in.' He would adopt a 'don't care' attitude to punishment. He was not unaffectionate but would never sit still long enough to be cuddled.

Examination

R.S.B. Form L. C.A. 5.0; M.A. 5.11; IQ 118. Good vocabulary, but poor finger control and an apparent inability to translate his space perception into motor activity.

His appearance was surprising: a tiny gnome, fair-haired, disproportionately large head, small arms, and a pale porcelain complexion, with high cheek colour. He showed no hesitation and talked throughout the interview with a torrent of words. He took no notice of the toys, he seemed rooted to the ground but had a number of mannerisms, such as rubbing his knee and twisting his body. He described his Dinky cars in great detail, their make and which of them won the races that they had, factually and without any imagination. He looked like a funny little old man. He embarked on a long tale of another boy's wickedness at school—calling out when not supposed to, not answering his name, and so on. He returned later to another long tale about 'one of the naughtiest boys there is'. Then he got involved in a circumstantial account of how somebody kicked him in the playground 'his name was George Bennet'. He continued to ignore the toys completely. He was quite wrapped up in his own world and unaware of immediate circumstances.

Hugh and his mother were taken on for treatment, but they only came 3 times, during which Mrs. A. expressed much inferiority feeling, especially in relation to her older sister. She worried that Hugh might become 'worse' before he got better. Then Hugh was ill and they failed several subsequent appointments. A year later Mrs. A. said that she had stopped attending the clinic because Hugh made scenes in the bus and she was ashamed of him. He was unchanged and in his mother's eyes 'as bad as ever'. Six months later the mother was still declining to reopen treatment.

Comment

Hugh was a waif who was lacking in basic orientation at a first-year level. His

recurring reaction pattern was one of difficulty in adapting to change. His continual crying in early infancy was not checked by feeding satisfaction; at 4 months his rejection of mixed feeding had been such that his mother continued bottle feeding for 2 years, thus depriving him of the most valuable instinct modification experience of the first year of life. On the other hand his easy conditioning to toilet training deprived him of the corresponding development in character. His lack of capacity for the modification of his instinctual pattern forced his mother to deprive him of the bottle suddenly, which had the effect of confirming his attitude of rejection of change.

Mrs. A.'s own immaturity, feelings of inferiority and unresolved sibling rivalry caused her to lack understanding of him and to deny him opportunities to gain experience. The vicious circle was that his feeding difficulties increased his sleeping and adaptation difficulties which, in turn, decreased his parents' ability to provide for his needs.

His cheekiness and defiance illustrated his inability to modify his instinctual demands. He had no pattern of compliance with a loved mother's wishes. He resisted her arbitrary control with all the tenacity of insecurity, clinging to the present through sheer lack of confidence in the future.

The clinical problem was complicated by his gross under-weight and poor state of nourishment, reflected in poor physique and strange appearance. He certainly needed treatment, but it failed because Mrs. A. could not, herself, tolerate any change in the situation, and had no confidence that anything new would be better.

REFUSAL TO GROW UP

Rose Y. (33) 20 months

Rose was referred by an aurist: talking started at 15 months but had since stopped, and for 3 months deafness had been suspected. She was an only child and shared her parents' bedroom. Mrs. Y. had 'an awful dread' of having children and could not go through another pregnancy.

Mr. Y. was 36, a precision tool maker, prone to minor illness. He was a good-natured man and Rose was 'a Daddy's girl'. Mrs. Y. was 26, and before marriage had been a floor supervisor in a textile firm. She was tense but co-operative and anxious to give as much information as possible. She found married life very dull and longed for someone with whom to discuss her troubles.

Pregnancy and birth were normal; labour 12 hours. The mother's first worry was that it took Rose 6 weeks to get back to her birth weight. The next worry, according to the mother, was that the midwife suggested that Rose had a peculiar-shaped head and would be an imbecile; and that her sexual development was not normal, so that she might change to a boy later. The same midwife had recently said that Rose's trouble was probably due to a tumour.

Feeding was always difficult, because of insufficient breast milk and failure to find satisfactory artificial food, until she took to cow's milk. Rose was still having an evening bottle at 20 months, 'otherwise she would never lie down'. She had a poor appetite and did not like sweets. She was advanced, responsive, and independent, 'she is really very active, won't sit in a high chair, hates being hemmed in or held down'. Toilet training caused great worry: 'I had her nicely trained at 4 months

until she was 9 months.' Rose then relapsed and at 20 months was refusing the pot. The mother said that she would go into hysterics and have scenes lasting half an hour.

Rose had never been happy and laughed little. Mrs. Y. thought that Rose had become very frightened, particularly of objects on the wall. 'Oh! she is frightened of things.' She did not mind being left alone for a little while and got on with the few children she met. She played little with her mother. 'Rose has more interest in clothes and enjoys new dresses.' On the other hand 'if you try to touch her she almost goes mad'. She was quite helpful at home, would help clearing up messes, and so on.

Rose started cutting back teeth at 15 months. She rubbed her ears and banged her head on her hand often. She was very sensitive to sound, woke at the slightest thing and was frightened of loud noises. She could say a few words at 15 months, but had since stopped saying words, but 'chatters in her own way'. She seemed more disturbed, but not to the extent that Mrs. Y. was particularly worried. However, friends said that Rose was paying no attention and this and her lack of speech made the mother feel she was deaf. 'Not stone deaf—she hears something, and some things she hears perfectly, such as sharp noises.' 'She takes no notice of noises and if you shout in her ear she does not respond.' 'She can hear aeroplanes but she did not take any notice of a road drill close by.' The mother said that she could hear a door bang and an adult cough, but not the wireless. She took no notice of being called. 'It nearly drives you mad, as one moment she hears and then the next you think she is stone deaf.'

Examination

No attempt was made to separate mother and child. She was a bright-eyed pretty girl, rather small but active. Rose would have nothing to do with anybody except her mother. She ran about the room and played mostly with runabout toys. Several times she suddenly ran across the room to climb upon her mother's knee, apparently agitated. She put her arm round her mother's neck but climbed down again immediately and went back to the toys. She dropped large toys and the loud noise seemed to give her pleasure, which would be inconsistent with total deafness.

She was not entirely unaware of the social situation and watched the doctor guardedly, and whenever he approached her she ran to her mother and climbed on her knee. She showed no sustained shyness or fear. She was unresponsive to shouting and loud noises, such as hand clapping; but once she responded to a low whistle. She responded to a new unexpected kind of noise, even of quite low intensity, sufficiently often to exclude total deafness.

Comment

It was impossible to arrive at a definite conclusion about Rose because the parents could not tolerate further enquiry.

Possibly the trouble started with an ear infection that caused intracerebral irritation. Alternatively Mrs. Y.'s nervous anxiety about bodily matters had made her pay too much attention to behaviour training. Rose had been very badly frustrated in early infancy feeding, and in spite of the mother's account, since all the aspects of

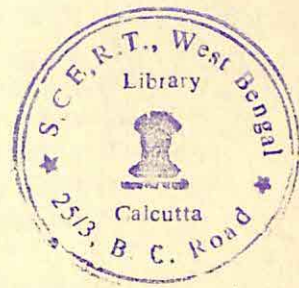
feeding had been difficult, it is unlikely that weaning had been easy. Rose, at least, had insisted upon keeping the bottle.

It was concluded that Rose's deafness was not total, and was selective. She had rejected auditory contact and had repressed responsiveness to social speech. She retained slight curiosity about inanimate noises and also babbled her own jargon. Her acute anxiety had caused a massive regression to babyhood in her emotional attitudes, though she had retained much of her motor development and skill. The prognosis seemed poor, partly because Mrs. Y. could not be held to a consistent course of action, such as keeping the child in treatment.

PART IV

Exploration and Habit Formation

(9 months to 2 years)



Chapter 9

Movement and Orientation in Space

DISORDERS OF RELATIONSHIP FORMATION—IN SPACE AND WITH OTHER HUMAN BEINGS

IN Chapter 7 we have considered the cases of children with severe disorders of relationship formation during the first few months. Next we come to some difficulties of the same order, but which appear first in a relationship system that has been more or less normal up to the age of about 1 to 2 years. In fact the two groups show in many respects a similar clinical picture and the case of Mark N. (16) is a link between them. Mark's lack of orientation dated from earliest infancy, but he, alone of his group of cases, showed certain integrating tendencies that enabled him to pass through the phase which will be discussed in this chapter, on the road to a more complete recovery.

In the period of life now under consideration (roughly 9 to 24 months), the active developmental processes are many and complicated. They include movement and orientation in space; the acquisition of motor skills; the extension of relationship systems; further instinct modification (which includes many important training experiences); and the control of aggressivity.

Reference has been made to a social or horde instinct concerned in the formation of the first maternal relationship (see pages 86-91). It is generally agreed that the urge to explore is a primary drive of mammals. Toddler children have a zest for exploration; an insatiable curiosity about what lies around the corner or behind the door, until they have organized a percept leading to a primitive concept of the locality.

The intense preoccupation of the suckling child with space and with objects within arms' reach enables him to co-ordinate his growing sensory and motor capacity, first in perception and then in conception of objects and objectives. In the second year of life, as the child becomes mobile, the range and scope of these activities will extend into relationships in three dimensions, into greater perspective and into the sphere of the independent movement of other bodies.

The more stressful learning experiences appear to exert the most lasting influence; e.g. falling and being hurt; getting burnt; and being temporarily separated from his mother, and lost. Out of the mosaic of these experiences the child comes to perceive environmental space; objects therein and their inter-relationships; movement in relation to himself and independently. He

will begin to grasp the principles upon which successful existence in the environment will depend. For example, he will come to an appreciation of the laws of gravity, in the form of a deep body feeling that will prevent him from stepping off a table into space, or taking other dangerous liberties with natural conditions.

The toddler's learning is remarkably dependent upon the basic maternal relationship. During his early infancy, the mother functions as the baby's ego, selecting and modifying the environmental influences bearing upon him, guiding his response. The baby particularizes his mother first, and only then turns to the recognition of parts of his own body and of objects within his grasp. Through early infancy he is drawn towards his mother and will relate his body and immediate surroundings to her and, through her, to the wider world. When he has related himself satisfactorily to his mother, the subject of self loses much of its interest for him. He will then take only occasional notice of his toes, or will manipulate his toys only when his attention is drawn to them by an adult.

When the child's relationship with his mother develops inadequately he will have less to draw him towards the outside world, to which to relate his newly perceived fingers, toes and rattles. There is a danger that he may remain wrapped up in his immediate surroundings, spending hours watching and sucking his fingers and toes, oblivious of the outside world. If he fails to relate his body to external objects he cannot perceive it as a unity; and if he fails to gain understanding of the essential unity of the parts of his body his exploration of his fingers and toes will never be completed.

Babies who are failing to relate their bodies to external objects will almost inevitably be late in crawling, but the more active will crawl not long after the normal age and will show the same intensity in their unceasing exploration of their surroundings. Once again, they will fail to organize their experience and this phase will tend to go on for ever.

A typical example was the behaviour in the clinic of a 15-month-old boy who could crawl upon his buttocks and heels. He crawled to the toy cupboard and pulled the half-door open by the knob. He placed his left hand over the edge of the closed half of the door and levered himself forward to peer behind the open half. He then rocked himself backwards and slammed the door shut, removing his left hand a split second before disaster. Almost immediately he repeated the operation at the rate of about 4 cycles per minute, until he was physically removed 10 minutes later. The only variation in the cycle was that occasionally he put his right hand on the shelf, picked up a wooden brick and set it down again. His mother said: 'Oh yes, he's awful about doors. He'd do that all day long to my kitchen door if only I let him. It drives you mad. And switches, he's crazy about switching on and off the light if he happens to be in reach of one when I'm carrying him.'

This style of behaviour is typical of these children; their perseveration and stereotyped actions appear to be relics of old conditioned reflexes that channel their unceasing motor impulses.

Less active children of this type remain still and are more obviously remote. The active child is in among things so much that the parents may not realize the extent of his remoteness from human contact. The remoteness of the inactive child is inescapable; he may sit upright for hours, gently rocking on his buttocks, remote and serene in mood. Sometimes he will appear to be 'sitting like patience on a monument smiling at grief'.

Movements are minimal—an occasional smile or frown flickers across the face. Sometimes the child is absorbed in watching the movements of his own fingers, movements which appear to have a special significance for him and which develop a wonderful complexity. His chuckles, grimaces and spasms of bodily movement are often taken as evidence of intrapsychic activity. Both inactive and hyperkinetic children are often subject to dramatic changes in apparent mood and are often thought to be deaf. The inactive or autistic child may be considered blind, too; whereas the hyperkinetic child dispels this notion by learning to run the maze of his familiar surroundings. Neither child is capable of organizing, and thus comprehending, visual or auditory experiences; therefore, though they may respond to sudden lights or sounds, they do not respond meaningfully to signals. Commonly they show paradoxical reactions to loud sounds or light—running from a low-flying aircraft, or panicking when the light is switched on or off.

Though there may be little real difference in the capacity of either over-active or in-active disorientated children to acquire motor skills, the over-active child will appear to outstrip the other, because of his greater activity. Motor landmarks will be reached late in both cases, but the hyperkinetic child may learn to walk only 2 or 3 months late. Commonly the last-mentioned will crawl around in a characteristically perseverating way and appear to take no notice of other people walking; then quite abruptly he will get to his feet and walk with little or no advance warning. Parents will remark, though no doubt this is a condensation, that the child suddenly got to his feet and walked perfectly, with flexed knees and with little of the wide-based, stiff-legged, staggering gait that is normally shown. The walking of the withdrawn child may be delayed many months, even years, and he appears to develop no conception of walking.

Other motor skills likewise: inactive children will play with their fingers all day long; and the hyperkinetic will manipulate objects; and both may develop a skill of finger movement that contrasts strangely with the use to which the movement is put. Hyperkinetic children will handle toys deftly but with no regard for the significance of the toy; they may perform astonishing acts of agility, balance and co-ordination without learning to perform a single functional act. Inactive children may develop a weird and wonderful

battery of apparently meaningless hand and finger movements that alone would distinguish them from simple aments.

In other words, both types of child may acquire peculiarly esoteric forms of motor skill that have little or no functional value, and little or no relationship to reality.

EXTENSION OF RELATIONSHIP SYSTEMS

To return to consider the path of normal development, the toddler will greatly extend his developing system of human relationships from that of the suckling period, which will have been limited by the amount of physical handling that he received. The suckling child recognizes and responds only to those who repeatedly pick him up, nurse him and feed him, and few infants will admit more than three adults into the inner circle, within the first year.

As the child's relationships grow more complex, a wide range of lesser distortions and partial failures of relationship formation will become possible, in addition to the total failures already considered among aments and to the primary failures in orientation (Chapter 7). A number of different but interacting factors have to be taken into account, e.g. the effect of failure and, therefore, absence of a function—as in the cases of the affectionless, hyperkinetic, autistic and withdrawn children described in the present chapter; the effect of specific reactions, both reparative and disintegrative—as in the psychosomatic reaction patterns described in Chapter 10; and more general reactions—which include the effects of partial developmental failure on the total reaction pattern, together with cumulative effects of disturbance of the time relations in the child's personal and social development, as illustrated in Chapter 11.

It is not practicable to separate defects of relationship extension from defects of instinct modification precisely, because the child's capacity for relationship formation will depend directly on his acceptance of longer term aims and of substitute satisfactions for his primitive instinctual drives.

It has been suggested that the infant is impelled into his first relationship at about the fourth month of life by the operation of the social or horde instinct. This is built up on a simple pain-pleasure cycle, but weaning is the first significant modification of instinctual pattern and it effects a refinement of the child-mother relationship that results in an increase in the child's ego strength. The child will then be ready for orientation in space relationships and, concurrently, ready to discriminate between different people, and animals, and to develop reciprocal relationships.

In the cases of autistic and hyperkinetic children, who have each failed in their own way to particularize their own bodies and to conceptualize the mother, relationship extension may be a lost cause from the start. They are likely to remain as clueless about other people as they have been about every-

thing else in the environment. But the absence of relationship formation is rarely absolute, and a whole range of disorder is met with, from extreme poverty of affect formation on the one hand to a minor impairment that will appear to be no more than 'coldness', on the other.

Infantile, dependent relationships will persist among severely autistic children in the form of a passive demand for a maternal type of care from any adult. Such children will often be 'trainable' by the establishment of conditioned reflexes, and may build up systems of special behaviour towards different adults. However, these are mere caricatures of genuine relationships.

Hyperkinetic children, though less remote seeming are usually, in fact, less compliant and 'trainable'. Their incessant impulses coming from within and expressed in motor activity are bound to interfere with the setting up of conditioned reflexes. Baffled parents will commonly complain that their child 'cannot be got at' and it may be impossible to build up anything resembling a relationship with him.

There are a number of more specific reaction patterns to disturbed relationship formation that are of considerable social importance. They have as a common origin, inadequacy of mother love, whether by reason of absence or interruption of maternal care, rejection by the mother, or poor quality of mother-love. In spite of a popular belief that 'spoiling' is due to 'too much mother-love', it is nearer the truth to state that it is impossible for a mother to love a baby too much. The apparent devotion with which many 'spoiling' mothers overwhelm their babies will usually be found to be due to the mother's neurotic urge to satisfy her own frustrated instinctual drives. Such devotion has little direct connection with the baby.

Specific reaction patterns to disturbed relationships usually take one of three main directions, according to constitutional factors and the environmental set-up: withdrawal, rejection, and compensation. Withdrawal will result in a backward baby, who does not maintain the normal pace of development; he is passive and unresponsive to his mother and he makes no effort to form other relationships. Rejection gives a very different pattern: an angry, difficult child who refuses overtures from the mother and from anyone else. Compensation may have two facets: first, the clinging, demanding child who holds on to the privileged position of babyhood and who may attempt to fight off all the other members of the family and to adhere to mother, solely and exclusively. The second facet is the child who tends to loosen the maternal tie and seek relationships with other people. 'She is all for her Daddy', a mother will say, 'I can't do anything for her myself.' The child, however, will be lucky to find an available adult able and willing to return the kind of love he or she wants, for such children are usually very regressed and their babyishness repels even their well-wishers.

Among the specific reaction patterns to disturbed relationships at this age, psychosomatic difficulties are notorious, and are reflected in feeding difficul-

ties after weaning, bowel disturbances, asthma, and skin troubles. These disturbances are also intimately bound up with problems of control of aggressivity, and will be discussed further below.

The general reaction patterns of children at this period are more important than the specific patterns, so important indeed, that they have given the period between teething and about 2½ years the reputation of storminess. Whether they be of out-turning or in-turning temperament, children in trouble at this age have in common the characteristic of regressing, whether this be shown in outgoing, demanding behaviour; or in withdrawal.

We shall consider in detail in Chapter II some cases of general disturbances dating from the second year of life and it will be seen that, though the children's behaviour resembles that found in the specific reaction, it tends in addition to permeate all the human relationships of the children involved. The withdrawn, regressed, babyish toddler will get into less trouble than the more aggressive, out-turning type, because he is less of a social irritant. People feel sorry for the former because he is such a 'poor little thing'. The regressed out-turning toddler demands the attention of everyone he meets, at an infantile level, which very few adults are prepared to concede. The resulting rejection of his overtures may increase the pressure of his behaviour and establish a vicious circle of bad relationship.

FURTHER INSTINCT MODIFICATION AND TRAINING EXPERIENCES

English mothers are apt to take the training of their toddler children very seriously, starting their campaign as soon as weaning has been completed; and perhaps it is better for parents to have no misgivings about their undertaking, for then, at least, all behaviour in the home will have a consistent pattern.

Reference has been made in Chapter 3 to the dilemma of English family life which has largely lost touch with tradition handed on by word of mouth. The majority of young mothers are not closely in touch with their own parents, who, in their own turn, were subject to strong social pressures to bring their children up to be independent and adaptive to a changing social pattern. Living in a rapidly changing society without the support of comfortable and familiar rhythms of life, young English parents are often understandably anxious to protect their toddlers by controlling them; yet parents will suffer cruel social pressure if their children turn out clinging and unadaptable. On the other hand, toddlers who are insufficiently protected and under-controlled will suffer anxiety, and may show regression or over-compensating aggressiveness.

Most English mothers will feel that their toddler is in need of a strong basic pattern of behaviour training. They will set store on their child's keeping to the general family pattern, by obedience and conformity. So long as they provide adequately for the child's emotional needs, there will be no

reason to anticipate trouble. A fundamental need of the child is to have an underlying security that will protect him from having to deal unaided with an environmental situation that will be too much for him. This situation is rather complex, though it will not trouble parents with good intuitive rapport. A child needs to have adequate satisfaction of instinctual drives and the protection that he has must not deprive him of this, nor must protection impede the process of instinct modification and impair the growth of ego strength. The child also needs to have opportunities for the exercise of his growing independence, and to make mistakes from which he can be rescued by an understanding adult in such a way as to increase his capacity for independence. The situation can be illustrated by reference to table manners and toilet training.

TABLE MANNERS

English families at most social levels value 'good' mealtime behaviour by quite young children. It will be recalled that weaning will modify the mode of satisfaction of the feeding instinct, but the goal will remain unchanged. From success in weaning the child will derive ego-strength and an enhanced relationship with the mother. The disadvantages accruing to failure have been discussed in the cases (21) to (26) (Chapter 8).

By her insistence on 'good' table behaviour, the mother goes a stage further. Taking food in common with others will at first be a forceful experience for a hungry child. The mother will have the task of striking a balance between concentrating on feeding the child, which may satisfy him but will not be conducive to his development; and making him take his turn, which may cause him serious frustration. The recurrent cycle of family meals is a very powerful agent for fitting the child into the family circle, and difficulties or dissatisfactions at mealtimes can have disastrous consequences for developing family solidarity.

At one extreme, a fastidious or anxious mother may continue to feed her child by spoon, long after the need to do so has passed. Many mothers cannot abide the child's mess, or are too impatient to tolerate his clumsy slowness, or are convinced that he is not getting enough. At the opposite extreme, a mother will sit a child at a table and demand that he comport himself like the others. Though the child may not yet be able to recognize the individuality of other children, he may be thought greedy if he attempts to corner all the food; and his harassed mother may introduce punishment to a sphere in which, for physiological as well as psychological reasons there should be contentment and mutual love. She may tell him not to make a mess, to hold the spoon properly and keep his elbows to his side, while expecting him to eat from a plate at the level of his eyes; all at a time when his grasp of language is still rudimentary.

The child can learn even if he cannot understand speech, nor yet suffi-

ciently recognize siblings to be able to copy their behaviour, provided that his weaning has resulted in trust of his mother and readiness to follow her through experiences that are strange at first. A child under pressure about table behaviour may lose his trust of his mother, with the consequence that he will regress in behaviour. He may withdraw and become timid and incapable of further growth in this field; he may become aggressive and rejecting of his mother's demands; or he may inhibit.

Since mealtimes constitute the focus of family life for most families, the ultimate consequences of mealtime difficulties may be impairment of the total attitude of children to their parents, which will have bad repercussions upon their capacity to enter into further instinct modification experiences and thus upon the formation of moral character. A possible result is that the child's idea of 'goodness' may remain fixed at a level of conformity to mother's will; and of 'badness' or 'naughtiness' to the reverse. Such a fixation may hinder him in the long progression towards being good through the operations of his own super-ego strength.

TOILET TRAINING

Toilet training is one of the most important and powerful experiences in the line of character formation. Reference has been made above to the common practice of establishing clean habits during infancy by conditioned reflexes, though the pattern of neurological development indicates that no child can be expected to control bladder and bowels voluntarily until he is in full and skilful control of his limbs.

During the toilet training of the toddler, the mother will give a good deal of attention to potting, being pleased each time the child performs and praising him; gently exhorting him each time he is wet or dirty, and showing him the pot. In an atmosphere of love and trust the child will get the idea quickly and will consciously co-operate. Towards the end of the second year his control of his bladder will extend to night-time. Should anything impair the atmosphere, the child will react characteristically according to his established reaction pattern, e.g. either ignoring the pot, protesting violently against it, being frightened of it, or becoming obsessed by it and demanding to sit on it for minutes at a time because 'wee-wee won't come' or 'not finished'. A typical inhibited reaction is for the child to sit for a long time doing nothing and, when released by a mother whose patience has become exhausted, to function later on the carpet.

Of course, a distinction should be made between bladder and bowel training. Both are strongly dependent on cultural factors but the moral implications of soiling are much greater than those of wetting. Bowel action, which may occur once or twice a day, is usually easy to control unless the mother is singularly inapt. The bladder, being more insistent in its demands, requires no little skill of the child for its control, especially all night.

Should difficulties occur in toilet training, the consequences may be long-lasting, even crippling; the worst being an impairment of family relationships. Here again, three classical reactions can be described. First, the in-turning child may be a passive non-cooperator. He may ignore the pot, which may provoke his mother into trying to force him into compliance, instead of leading him towards taking responsibility for himself. It is a moot point whether such coercion is a more disastrous pattern for the moral development of the child than the alternative course of the mother continuing indefinitely to treat her child like a baby. Secondly, the out-turning child may actively resist pot training, and this may lead to open warfare. If the mother wins, the child's individuality may be impaired; if the child wins, his opportunity for advance will have been lost, and he may be left with an excessive burden of aggressive feelings without the capacity to control them. Thirdly, the child may inhibit and thus not only lose in development, but also stand in some danger of suffering a similar paralysis when faced with later forward movements in development.

The untrained child normally has neutral feelings about urine or excrement, before training is started. Some mothers, by praising the child for using the pot, may induce interest in excreta, most children have some spontaneous interest. Many toddlers become visibly proud of passing a large quantity, a pride that will probably remain so long as it is customary to talk of 'a good bowel action'. It is common for untrained children to touch their faeces and to smear, with no apparent disgust. During training, children encounter the pressure of adult attitudes, including expressions of disgust at soiling, and pleasure when the offering is safely laid in the pot.

The position of the child in toilet training is somewhat confusing: at first excrement has a neutral value, and then acquires a 'good' quality from the mother's pleasure at successful bowel actions; but then becomes 'nasty', 'dirty', or 'bad' if not placed in the pot. So the 'bad' object becomes 'good' if dealt with as mother wishes. In the face of the complexity of emotions roused by toilet training some children shrink from, or avoid the toilet training situation.

The child has produced these good/bad objects from his own body, by his own efforts. To defæcate and micturate are two of the very few things he can do unaided. In one sense, to perform into the pot is to make an offering to the mother. If she responds by a loving, grateful reception, the child will have discovered one way of turning bad into good, for normally he will identify with his mother's evaluation of what is good and what is bad. Not only will he have learnt how to control the bad and turn it into good, but he will also have learnt to recognize examples of 'good' and 'bad', and thus to begin to distinguish between them. This may represent a primitive beginning in moral formulation.

Toilet training difficulties carry some risk of the impairment of the child's

relationship system. In the course of a premature toilet training attempt it is only too easy for an impatient mother to become irritated and punitive when her child's toilet conditioned reflex breaks down; and this may be the thin end of a wedge of estrangement between them. If, as so often happens, weaning is proceeding at the same time, the child's difficulties in control of aggression may complicate the issue.

During the second year of life when toilet training is undertaken or restarted, the child whose relationships have been impaired by premature toilet troubles may react sharply and unfortunately; and other children with imperfect maternal relationships, likewise. The prize at stake is the child's first important lesson in distinguishing good from bad and in learning how to control the bad.

Normally, toilet training proceeds in a way reminiscent of weaning, in which the child follows his mother into a new way of life on the basis of mutual trust. The child's love for his mother makes him compliant with her wishes, provided she understands his needs. If the mother wishes excrement to be dealt with in a certain way, the child has no *a priori* objection. The process quickly goes further, for the child will adopt his mother's attitude to the affair. The mother will stigmatize faeces as 'dirty', and wetting as 'naughty'. The child will go further and may take an excessively strict attitude. Whereas previously he may have smeared himself happily, he will now show excessive distress at a slight mistake. This excessively moral reaction has been called *reaction formation* and it is an intermediate step towards character development. This 'intermediate step' will settle down into stable super-ego formation during the next period of childhood.

An in-turning reaction, as has been indicated, is marked by withdrawal, babyishness and failure to encompass the new responsibility of cleanliness. This will inevitably weaken the baby's ego and will delay or weaken super-ego formation, too. Total toilet training failure is exceptional, but the process may be prolonged; the child may remain unreliable and dependent upon close supervision for many months. Looking further ahead, a similar over-dependent, babyish approach may mark the child's later moral advances, and neither child nor mother will derive much satisfaction from these experiences.

The lack of satisfaction that these children will derive from developmental advances is often striking. In general they have a poor morale in undertaking anything new, and are easily discouraged when in difficulty. They usually develop strong inferiority feelings that hamstring such efforts as they are capable of, which together with their babyish dependence will make them appear 'wet'.

Later, a physical complication may arise, for if the child never acquires a dry habit at night the bladder capacity may remain small. This will hamper later voluntary attempts to gain control of the situation.

An out-turning reaction is more dramatic, causes far more trouble but is

probably less harmful to character formation in the long run. This reaction is marked by antagonism to training, and sometimes outright rejection. The outcome will be determined by the resolution of the relationship situation, for an antagonistic child who rejects training may goad his mother past bearing. The great danger will be that the child's negative reaction will spread to all forms of parental training, including the acceptance of the 'good' and rejection of the 'bad'. This, together with the strength of the feelings aroused, and the child's poor ability to control them, may cause untold difficulty.

The resulting character pattern will be explosive: sudden violent storms completely out of control; or, at a lower level of emotional tension, an impulsiveness and over-excitability, so that the child is unable to wait for anything. A small bladder in the case of an out-turning child may have the added complication of hypertonus, excitability and impetuosity, and may result in day-time toilet accidents.

At its extreme, the negative out-turning reaction will lead to the outright rejection of all morality and human ties of affection, but this, fortunately for the race, is extremely rare.

The reaction of the inhibited child is complex and may lead to the development of serious character deformities that are not as dramatic as the foregoing but will be, in some ways, more crippling. The foremost difficulties are disorders of the control and expression of aggressivity and these will be discussed in the section immediately following. In addition, there may be serious difficulties in the sphere of spontaneity and responsiveness.

One type of character formation is marked by lack of generosity, inability to give, and sometimes meanness, hoarding and miserliness. Another type of character development may result in over-control, obsessional concern with tidiness, cleanliness and order, and in fact may be one of the main sources of origin of the obsessional character.

The origin of meanness is not difficult to trace; the child reacts in an inhibited way to the storms and difficulties of the mother's pot training. The inhibiting child then withdraws from the situation, with the result that when anyone makes demands upon this child to do anything he will inhibit and no gift will be forthcoming. This may mean a serious distortion of the child's normal scale of values and will leave the way open to the development of meanness and miserliness.

In the obsessional type, the child's reaction formation becomes very strong. His value system will not develop any further than order, tidiness and cleanliness and control, which will mean everything to him and the converse states of disorder, untidiness and dirtiness may arouse unbearable anxiety. Many children will far exceed the normal evaluation of cleanliness and develop behaviour that appears to be aimed at gaining control of all situations by means of rigid obsessional mechanisms. Later, in the 'magical' period of

childhood, these children may adopt magical gestures or have strange rituals that bring them some comfort. Children will frequently become inseparable from a piece of old blanket or an ancient toy, or something that appears useless and even disgusting to adults. Parents will sometimes throw this ritualistic object into the dustbin in the interests of hygiene, and will be shocked at the fury of the storm that this action provokes.

The late result of this obsession formation will be over-dependence on order, tidiness and method. In moderation this may be no great disadvantage, but in extreme form the person concerned may be quite unable to operate in a situation which is in the least disorderly or unorganized. Working colleagues of the severely obsessional person will discover how crippling this condition can be, and how difficult it can make life not only for the sufferer but for everyone around.

Something may be added with advantage about toilet training by a neutral agency. Just as the resolution of difficult weaning problems by a nurse or experienced child minder will lose for the child the main character building effects of weaning by the mother, so the resolution of toilet training difficulties by a neutral person will result in the child acquiring the new skill at a low tension, as it were, of emotional relationship. The resulting increase in super-ego strength and control will be slight, if any. If the mother who has failed in toilet training is able to build up the relationship with her child again as if they had gone through the experience together, the position may be retrievable, but unfortunately mothers so placed commonly suffer such an undermining of confidence and personal morale as to be unskilful in building up the relationship again. It is a sounder procedure to help the mother to resolve the difficulty herself, rather than to take the child away and do it for her.

CONTROL OF AGGRESSIVITY

Disorders of the control of aggression loom very large among children's difficulties at the toddler period. The storminess of the toddler period is advertised in phrases like 'the terrible twos'. We have traced the emergence of aggressivity and of its control measures, from the time of teething. At first these measures of control are primitive and consist of little more than the mother exercising control over the child's feelings on his behalf. When the toddler becomes mobile, it becomes imperative for the child to gain adequate control of his own aggressiveness for himself, and to build up a system of reference that will operate when the parent is not present. Normally this will be effected by a process of identification with the parent, and by reaction formation. Because of the child's strong relationship with and dependence upon the parent he will be guided by the parent's values in so far as he can understand them, and this is a very important aspect of identification.

The toddler not only takes after and resembles his parents in very many

respects, but for long periods he will adopt his parents' attitudes and almost *be* his parents. So far is he apt to go that he will over-evaluate what his parents regard as good and naughty respectively, and 'reaction formation' will appear. With experience later of meeting with successes and disasters under more remote parental control, the child's reaction formation will sober down into a more objective system of right and wrong, and of ideals. The goals of the toddler will remain immediate, and will be based on primitive black and white moral values. At first he will recognize only good and bad, and because of identification with mother and father, he will love the good and reject the bad. As his capacity for observation and reasoning increases he will begin to understand the principles underlying his parents' 'good' and 'bad', and so will be not quite so dependent on direct intervention by the parents. This lengthy process will occupy most of childhood.

Identification with the parents' good and rejection of the parents' bad will involve much modification of primitive instinctual drives, the frustration of which will arouse aggressive feelings and actions in the child. With a normal child-parent relationship the identification of the child with the parent will result in the child gaining control of his feelings for himself. Control is one of the parents' 'goods', but it takes some time to establish. Most children between the ages of 18 months and 3 years are subject to temper tantrums occasionally when frustrated, and the future of their pattern of aggressivity will depend upon wise parental handling.

The three usual patterns of difficulty can be seen. The in-turning child will fail to cope with the new situation and will be regressed, timid and babyish. His in-turning behaviour will result in little arousal of strong aggressive feelings because he does not much deploy his instinctual drives outwards. These latter tend to remain at a primitive level of immediate satisfaction and, if denied, will drive him into in-turning self gratification behaviour. If the mother continues to satisfy his instinctual drives at a babyish level, he will remain fixed in a babyish state of development. If the mother presses her child to grow up, she may set up a depressive trend in his character formation; a tendency to suffer from strong inferiority feelings, anxiety and depression.

The out-turning character pattern will be associated with violence. With a greater degree of control a tense child will result, one who is always on the edge of emotional outbursts with very slight provocation. At a less intense level, the child will be impulsive and excitable; he cannot be told of any treat or pleasure beforehand lest he be sick or sleepless, behaviour which is frequently mistaken for 'showing off'. With a lesser degree of control, open, terrible and uncontrollable temper tantrums may result at even very slight degrees of frustration. Few children can stand repeated severe tantrums for long without becoming acutely anxious or else inhibited.

Somewhere between the violent out-turning and the inhibiting reaction there is a condition in which the aggressiveness of the child remains fairly

well controlled during the day, but at night the child suffers from interrupted sleep, nightmares, night terrors, sleepwalking and so on. It is generally true of such children that they look pale-faced and strained during the day and the parents will complain that they sleep heavily and restlessly. They are prone to night-time states of terror from which they may be very hard to rouse. As usual, partial and incomplete reactions are more common than complete states of lack of control. In an incomplete reaction the child is touchy, unable to move spontaneously and smoothly into any new activity, but he will, rather, go off like an arrow released from a bow, pouring energy into an activity regardless of what is needed.

The seriously inhibited reaction resembles that seen at the time of weaning, with due allowance for the added capacities of the toddler child. The child's over-control will show up markedly in his physical incompetence, timidity and unadventurousness in space exploration. This may result in a sheer lack of skill through lack of practice and inability to give himself to learning. When inhibition is combined with a strong out-turning temperament the result may be paradoxical; the child will seem open and friendly, unlike the inhibited in-turning child with whom it is difficult to make contact, but will show a curiously intractable incompetence in dealing with new developments. It is likely that serious inhibition will be accompanied by obsessional mechanisms and ritualistic behaviour.

AUTISM AND WITHDRAWAL

Phyllis B. (34) 3 years

Phyllis was very backward in play and speech, and in discrimination between people. Her vocabulary consisted of about 5 words, and she did not use her hands.

Phyllis's parents were careful, kindly people. Mr. B. was a clerk, and they lived rent free in return for some caretaking duties. Phyllis had been much wanted, her mother's only pregnancy, 8 years after marriage. Pregnancy and birth normal; breast fed for 9 months. She was an exceptionally good, quiet and placid baby, who could be left in a play-pen for hours, quietly rocking and sucking her toys, without demanding attention.

Her life was uneventful to a sinister degree. She never used her hands purposefully, and at 3 did not attempt to hold a spoon. She could feed herself to some extent with her hands. Early pot training was unsuccessful, she had no notion of cleanliness. During a home visit Phyllis was placidly and passively friendly, remaining so while her mother left the room for several minutes. Mrs. B. said that at 9 months Phyllis could be kept quiet by the sight of herself in a mirror, so they fixed a large mirror against the side of the play-pen. Phyllis had spent many hours sitting and looking at herself while her parents worked.

Examination

Griffiths Developmental Scale, mental age 45 weeks (G.Q. 33; Locomotor D.Q. 42). When fetched for examination, she sat bolt upright on her mother's arm, not

having paused for one moment in talking baby jargon. Her social behaviour was cheerful and indiscriminating. She touched 5 people present in the room, in turn, and gazed at the doctor, whom she leant against while sucking or fiddling with a toy. Her play was quite rudimentary.

She showed echopraxia; seemed inaccessible to suggestion; when a hand was held out she laid her own hand in it, but did not grip it. She allowed herself to be nursed like a young baby—passively abandoning herself to the rocking motion.

Mrs. B. appeared to be very tense and Mr. B. obsessional. The former said: 'Phyllis does not recognize toys for what they are and she does not bother when they are taken away from her.' The parents' first worry had been that Phyllis had not held things normally, and ignored toys. Early infancy had been exceptionally peaceful, she had always to be wakened for feeds. Neighbours had said: 'Have you really got a baby in your house?'

There had been occasional short phases of screaming, and in one phase at 12 months Phyllis had had a fortnight of unceasing activity. She then learned to walk and promptly became placid again.

The outlook for Phyllis seemed poor, but something had to be attempted. The mother was helped to be more active with her child—talking, stimulating and playing with her as much as possible. Phyllis became livelier and seemed more in touch with her family. A month with her mother at the grandparents' home improved matters; and at the age of 3.8 years, she was tried out in a day nursery, to give her mother a respite. This was not a success; the matron remarked that Phyllis seemed friendly and did not mind being left. If allowed, she spent all day running around ignoring toys and other children. She fought against a midday rest. She was wet and dirty, would not use a spoon and resisted being fed, but took handfuls of food while running around. She called people 'Daddy' or 'Mummy' and spoke only isolated words. Rarely, she listened to music, but usually only sucked toys. She ignored group play.

The nursery staff became increasingly anxious in dealing with her, and thought that her behaviour adversely affected the other children.

At re-examination a few weeks later, she was more out-turning. Her deceptively charming and easy manner covered a profound lack of contact. She had a few more words and seemed vaguely aware of the use of some common objects. She remained indiscriminating in social contacts.

At 4.2 years Mrs. B. was ill and Phyllis went to a particularly understanding foster mother. Phyllis's social insensitivity, combined with increasing mobility and wider range of ideas, caused difficulty and danger. She could not be left alone, pulled things off the table, tipped over furniture, jumped from window ledges, fell down-stairs. She screamed loudly, both in protest and apparently meaninglessly. She slept about 5 hours each night. 'She never sees where she is walking and steps out of the pram or off steps as if she were on level ground, also she will walk on the dog or cat if they are in her path.' She enjoyed being cuddled and talked about Daddy, 'making a bee-line for any man she sees'. Passive movement always quietened her. 'She enjoys a private joke.'

Mrs. B.'s anxiety culminated in serious skin trouble that necessitated about 3 months in hospital, and Phyllis continued living in an impersonal world. The housing authority failed to meet this family's pathetic need for help, and the special

therapeutic community for which Phyllis was destined had to keep her waiting for admission. She had a fortnight there under observation at a moment of more than usually acute family hardship, but conflicting medical advice confused the issue. The doctor there criticized the parents for not allowing Phyllis to grow up and become more independent. Since the parents' handling of their child, under medical advice over the previous 18 months, had had the object of returning Phyllis to an infantile level of relationships, their anxiety was augmented by this conflict.

At 4.8 years, Phyllis was admitted to the local day Occupation Centre (for mental defectives), in order to introduce her to social life. She appeared to like it and was always keen to go to 'school' each morning. Re-examined at 4.9 years, Phyllis gave a remarkable display of hyperkinetic behaviour as she pottered around among the toys and people in the room, quite without discrimination. Her level of integration of behaviour was rising, though she was patchy; her training was still limited to establishing conditioned reflexes.

Comment

In retrospect it appears that Phyllis's difficulties arose during the early relationship formation phase, but at the time of examination they constituted a toddler rather than an infancy problem.

It seems, though this is largely speculation, that Phyllis was basically of an out-turning temperament, but weak in social instinct. She formed only the most tenuous of infant relationships. Social conditions caused her parents to take advantage of her compliance with being left alone with a mirror. In her contemplation of her image, in an unreal world, her outgoing drives appear to have become lost. She failed in social discrimination and her space exploration activities were unprogressive. Her incomplete *gestalt* formation caused patchy, perseverating and basically uncomprehending behaviour. Her purely motor activities were little retarded; but her social habit training was reduced merely to conditioning. Her apparent friendliness and motor skill misled people into the belief that with a little parental encouragement she could be 'allowed to grow up'; but her lack of instinctual modification and, therefore, of normal character formation passed unnoticed. Only her parents knew from sad experience what they were up against, and the knowledge greatly augmented their anxiety. The mother's collapse caused a break in the maternal-child relationship at a particularly unfortunate period.

Phyllis gives rise to alternating hope and despair; hope springs from her apparent capacity to adapt and to advance, and from the formation of conditioned behaviour patterns; and despair when, after periodic bursts of out-turning activity, her lack of character formation again becomes apparent. As she gets older more will be expected from her by the people who can least tolerate her type of behaviour. The community therapeutic resources are quite inadequate, and she does not show evidence of that high intelligence and integrating tendency that enabled Mark N. (16) to develop in the sphere of cognitive activity later. In Phyllis's case, the basis of hope is sadly insecure.

Suzanne B. (35) 4.7 years

Suzanne resembled Phyllis in general pattern of behaviour but nothing was known

about her early infancy. Suzanne was adopted from an orphanage at 10 months, as an act of disinterested charity by a childless couple. Several changes of care had left her at 10 months in a 'terribly bad physical condition, very small, undernourished and too weak to sit up'. She weighed 18 lb. Her tragic need influenced the adopters, in spite of medical warnings.

Suzanne took kindly to her new mother and was soon sitting up. At 12 months she seemed lively and said a few words. The father's foreign service appointment took them abroad, and for a year Mrs. B. was preoccupied with social duties and left Suzanne to a locally recruited nannie. There were no complaints, feeding was easy, she gained weight, but she needed an unusual amount of sleep. Her vocabulary at 2 included about 20 words in 3 languages.

At 25 months the parents adopted a 2-month-old boy—Tommy, and the effect on Suzanne was disastrous. Misunderstanding at first, they attributed Suzanne's decline to a very hot spell. She became nervous and upset; stopped feeding and talking. She attacked the baby, but at other times stood in a corner, solitary, for quite long periods. She would stand still, passing her weight from foot to foot. They wondered if she were deaf.

Next, the family lived uncomfortably in a hotel for some months. Suzanne behaved 'like an angel'—was quiet, undemanding, withdrawn and silent. At 3 years she started ugly, throaty, meaningless noises, which habit died out slowly after a year. At 3½ she would follow her father around the house, copying him and gradually became more amenable to gesture and sign.

At 4 years a complete medical examination reported poor muscular development but normal reflexes; no ocular fixation, but normal fundi. X-ray of cranium was normal. E.E.G. recorded a basic slow rhythm, with a predominant theta rhythm in all leads—not abnormal for her age. No evidence of any epileptic or space occupying lesion.

At 4.4 years the parents, faced with a 3 months' absence abroad, departed with Tommy, leaving Suzanne with the mother's sister who lived with them. Suzanne refused food for some days and was wet and dirty—unusual for her. Her behaviour then became patchy and unpredictable: some days, impossibly restless, noisy, tempestuous and screaming; other days, listless and totally unco-operative; sometimes happier and playing like a 3-year-old. The aunt became unnerved and brought Suzanne for examination.

At 4.7 years, Suzanne was noticeably undersized and restless. She ran around in the corridors, entering any open door. She penetrated to the kitchen on the floor below, but returned unaided. She allowed herself to be led off, without a backward glance. Her behaviour was hyperkinetic and purely exploratory. She kept switching the light on and off. Noise attracted her momentarily, but nothing held her attention. She unwound string from a stick, quite skilfully, only to stuff the string into her mouth. She said something like 'hello' into the telephone, but not into the mouthpiece.

Her play was at a level of crude movement, picking up a toy, waving it in the air, stuffing it in her mouth and putting it down again. She showed obsession and perseverance in picking up a handful of small, brightly coloured, wooden sticks which she spilt on the floor and picked some of them up again. She then turned a tap on and off, picked up and put down some red halma men, then spilt some more

sticks. For several minutes she perseverated between spilling sticks and picking them up again, with a slightly stronger tendency to the latter.

She led the doctor by the hand towards the toy cupboard but lost the thread of her activity in the middle of the room. Then the doctor picked her up in mid-activity and she whimpered and struggled to get off his knee, but though not held, she did not get off. The doctor then rocked her rhythmically, and for about 10 seconds she abandoned herself to the motion. Then, she stiffened, whimpered again and climbed off. Immediately her expression became placid, she took two steps away, but suddenly turned around, half climbing on the doctor's knee again, stopped and went to the cupboard door for perhaps the twentieth time. This fragmented perseveration was typical of her activity.

When Mr. and Mrs. B. returned from abroad, Suzanne was agitated and clung to her mother for 2 days. She cried continuously, almost the first time she had cried for a cause other than motor frustration. She settled down quickly and played with Tommy for the first time, if play be the correct term.

The parents saw that there must be no more separations if anything were to be saved from the shipwreck of Suzanne's development. The aunt stayed on to help the mother and a home teacher came for 2 hours each day. It was, perhaps, not ideal to involve so many adults, but Mrs. B. had become very anxious over her failure and needed support.

Contact was sought with Suzanne by every possible means, including nursing and cuddling like a baby as far as she would allow. Particular care was taken to prevent Suzanne's absorption in her obsessional preoccupations, by breaking up her activities with variegated stimulation. Six months later she was being more equable in mood, usually happy, and played quite well with Tommy. She said 'Mummy', but nothing else, and was trying to whistle. She sat still for 15 minutes at the hairdressers—a record. She was more cuddly, and also had made some sort of friendship with a neighbour's boy. When seen at hospital, however, she was as hyperkinetic and autistic as ever, but this might have been a sign of greater receptivity to the environment and more organization of response.

Comment

Evidently Suzanne had had no infancy. At 10 months she was a tiny baby and had no relationships; but her immediate response to adoption was favourable. Unfortunately, no sooner did she find a mother than she lost her again, and under the care of a foreign nannie, her progress was slow and uncertain. She retained sufficient maternal relationship to be jealous of Tommy, but it was a tenuous relationship, and her jealousy was uncontrollable. She had insufficient identification with her mother to adopt something of the latter's attitude.

Jealousy was accompanied by disastrous regression, she stopped talking and became solitary and inaccessible. One year later she was showing signs of recovery but, unhappily, her parents went away again for 3 months and she regressed again.

Suzanne's reaction to the deficiency of her interpersonal relationship formation was out-turning and hyperkinetic. Her unmodified instinctual drives still demanded prompt satisfaction, whatever the circumstance. Her patchy space orientation lacked abstraction, she was restless in a new place and understood nothing from her unorganized explorations. She was totally unreliable in the street and did not under-

stand traffic. She filled in the gaps in her understanding with restless, fragmented and perseverating behaviour, often set in a fixed pattern of ritual.

Repeatedly when hope was nearly extinguished she would show a slight advance in understanding and a new acquisition that kept hope alive. The prognosis was very bad, unhappily.

AUTISM, WITHDRAWAL AND TENDENCY TO RECOVER

Tim T. (36) 6.8 years

The parents complained mostly of Tim's school difficulties. He had started badly, refused food at school and was often sick in the mornings. He did not mix and was 2 years behind the other children. He could not hold a pen properly and had only recently learnt how to wind up a clockwork toy. At home he was excitable and easily upset. He had 'manias', e.g. he would spin anything he caught hold of.

The father was a solicitor. The parents had married late, and the mother's 3 months' pregnancy was discovered during laparotomy for a suspected ovarian cyst. Fibroids were removed. The confinement was prolonged and Tim was shocked for 48 hours. He made a good recovery and fed well on the breast for 9 months.

The T. family life was methodical and rather rigid. Tim walked at about 2 years and talked at 3. He refused a pot until he was 3 but later became excessively clean.

At 3 his parents left him in his own home with the cleaner and her 3 children for 2 weeks. Upon their return he seemed upset, sullen and clinging. One year later his parents went away for a week, and he stayed in the cleaner's house. He was very upset, and one night was found walking towards his own home. Subsequently he resisted separation from his mother.

At 4.2 his sister Harriet was born; Tim showed some jealousy and became even more babyish, but later took little notice of her.

His mother thought he lacked confidence and when frustrated, he either withdrew or else became explosive. Generally he was timid, disliked leaving the house, and clung to his mother. He never joined in with other children spontaneously but preferred to help his mother alone. He would lay the table meticulously, but his movements were slow and fumbling, unlike Harriet's quickness.

Examination

R.S.B. Form L. C.A. 6.9; M.A. 4.10; IQ 72. Basal age 3.6 years, scatter to year VII; a strong tendency to perseverate. Retested 2 weeks later, R.S.B. Form M. M.A. 5.10; IQ 86; scatter years IV to VIII. He was more co-operative, but still showed perseveration. He dealt with numbers up to 13 with confidence; his verbal reasoning was patchy and he gave some bizarre verbal responses.

During examination his play was babyish, mainly placing doll's furniture in the sand tray, naming each object in a kind of recitation, as follows: 'That is the bath we pull the plug out. That is the toilet we pull the plug. That is the basin we pull the plug out. That is the table we sit on. That is the stool we sit on.'

He took little notice of the doctor, but looked at him occasionally with a fixed grin. He talked unceasingly into the air. He had a mannerism of rolling small objects between his hands.

His style of conversation can be illustrated by quotation: 'I had my hair cut

yesterday. I like having the toys here. I like all the things here except the toilet. I liked that cot didn't I?' He was intolerant of sand on his hands.

The headmaster of his school reported disquietingly: 'The main problem is his general uncontrol. He has a mannerism of flapping his hands up and down, for long periods, but his worst tantrums occur when his routine is disturbed, e.g. when his special teacher is away, or when he loses a glove. Then he will scream, and flap and bring the house down in his distress.'

He was often irrelevant, e.g. when asked 'What is your name?' he might reply 'That's my chair'. On the whole he irritated other children and wandered about alone, watching the water trickle out of drain pipes. On the other hand, he led the class in the Christmas play, knowing all the words and cues. The headmaster commented. 'He does not seem unintelligent when you can get at it.'

His school progress was impeded by poor manipulation control, and the discrepancy between his size and his attainments was increasing.

Comment

There were several anomalies in Tim's case in which it differed from that of a straightforward educational subnormality.

His delay in reaching the main motor landmarks was out of proportion to his later retardation. Walking, talking and toilet training occupied nearly twice the normal time, which is inconsistent with an IQ of 86. His clumsiness and poor motor co-ordination contrasted with a good vocabulary and sentence construction. He had little practical sense and at 6 could not wind up a clockwork toy for himself. Although charming and friendly, he had neither friends nor social capacity. His only relationships were with his elderly parents, but at a babyish level. His verbal-performance ratio was the reverse of that characteristic of an E.S.N. child. Lastly, his peculiar perseverating play belonged to no category of mental defectives.

The key is in Tim's partial failure to form relationships—human and inanimate. He had a poor start and a rigid, methodical upbringing. Brain damage might account for some of his motor deficiencies, but this cannot be decided.

Tim's refusal of all the great habit training experiences indicated a poor state of relationship. Hence he was lacking in the space orientation experiences of the second year and his motor skill, co-ordination, powers of perception and of conceptualization of his immediate environment were under-developed. His elderly parents' lack of baby small-talk had caused speech retardation which was increased by the usual vicious circle of silence with a mute child, due to the difficulties in communication experienced by the parents.

His parents could neither play with him at his level, nor introduce him to his peer group. He went to school lacking social experience, lacking deep body comprehension of the physical world, uncertain and ill co-ordinated in his movements. In a rigid behaviour pattern something of his ability could emerge—as in the example of the Christmas play. When his familiar surroundings were disturbed, he became anxious, as in the two periods of separation, which had augmented his total lack of orientation.

Mark N. (16), page 110, shows an example of cognitive orientation at around the age of 6–8 years, and likewise Tim's bizarre and perseverating verbalizations at play may have represented the beginnings of cognitive organization, still in a primitive

stage. However, his perseverance would probably continue until his conceptual processes had organized considerably more.

Tim's urgent needs were to regain some of his lost toddler period, which might possibly be achieved by encouraging him to have the physical experiences of that age, protecting him against social discrimination and helping him to increase his cognitive organization. All three needs are most difficult to provide for.

James L. (37) 6.4 years

James differed from Tim T. (36) in that his difficulties were less in space orientation and more in human relationships.

James's parents were educated well-to-do people; his sister, Marguerite, was 3 years younger. James was backward and a misfit at school; but had lately made a quite striking educational advance.

Labour prolonged, face to pubis presentation, and oxygen was given neonatally for shock. Birth weight 8 lb.; breast feeding started slowly, his mother said 'He was very sleepy, everyone said how good he was.' Later he became voracious, 'he has a fiery nature', and usually returned a proportion of each feed.

He had no grasp reflex and, early on, was unresponsive. The mother said 'I put him in the pram as much as possible, and he didn't have much nursing and cuddling; I wanted to do more cossetting only he didn't seem to need it. It's my fault that he missed it.'

He had to be held up in his bath for longer than his mother expected. She said: 'I had a curious sensation he didn't know where his toes were, he didn't seem to be aware of his own body.'

He vigorously resisted weaning, 'it was the first new thing he had to do in life and every new thing he has found mighty difficult.' Other learning was similar. He walked late, but suddenly: 'he ran before he walked, almost; he was terribly fearless. When he was about 19 months old we went to the seaside, and as soon as he got on to the beach he ran straight into the sea up to his neck, and might have gone on if we hadn't caught him up.'

He did not play properly and took little notice of his parents up to the age of 3, he was indiscriminately friendly with any adult, but not 'over-affectionate'. From 2 years he had had rigid, obsessional patterns of behaviour, e.g. a compulsion to touch everything with his lips, which he still retained, at times, at 6.

From an early age he had been incompetent in practical matters. He was still unwilling to dress himself. Although unresponsive to his parents he was very attached to his toys and fussy about detail. His father described him as 'a routine chap'.

His energy, strength and general good nature were inexhaustible but he did not particularize between people.

More recently his behaviour had become both more organized and, in some respects, more peculiar. When once he started talking, he chattered excessively. He developed curious rigidities, e.g. on some days he would demand to have his bedroom door open and other days closed, and would become upset if thwarted. Sometimes, in uncontrollable rage he would put his hands round his mother's neck in a gesture of strangling her. His lack of social discrimination was shown by threatening an older boy at school: 'I'll kick you to pieces.'

He went to a nursery school at 4½ and it took him about 18 months to become

incorporated into school life. At 6½ his only 'trouble' was that he was too big, physically, for the children of his educational standard. 'He is willing and able to work and play with children from 2 to 3 years younger than himself,' the teacher wrote, 'in the last 3 months he has begun to show a real interest in learning his alphabet and the numerals. His efforts at writing are still primitive, but more sustained and his use of paint and crayon more accurate. His speech is not backward, but more grammatical than most children's. He is very observant and has a good memory despite appearances to the contrary.'

James was a nice-looking little boy. He was not shy, but talked without stopping in a loud, dictatorial sounding voice. He remarked in a loud voice that a painter in the corridor was bald. He asked innumerable questions: 'Why are there so many nurses? Who was the first person who was ill? Why do the nurses have hats on?' He showed marked perseverance. When asked which school he went to, he replied 'Where the little boys go to. I'm the oldest. All the others are little. Robert's big too. Sheila's little,' and so on until interrupted by hearing the hoot of a taxi or a footstep next door. He appeared to have an enormous store of energy, and of ill-understood and undigested experiences.

Comment

James had evidently made a partial recovery from a slow start. Anoxia at birth concealed his true out-turning temperament for several months. It might be that the initial brain damage prevented him from putting out normal feelers into a relationship with his mother. His sleepy start, undemanding behaviour in everything except feeding, resulted in hours of well-intentioned neglect that deprived him not only of his relationship with his mother, but of exploration of the environment and of experience of accepting change of instinctual patterns of living.

Subsequently his true out-turning temperament made him plunge into second-year life with little or no understanding. His mother felt that he did not know where his toes were, was not aware of his own body. His dramatic, headlong dash into the sea at 19 months showed that his lack of orientation was combined with intense activity. Moreover, as the variables of behaviour increased, his rigidity became more obvious.

In spite of these disabilities, he had a general friendliness, he quickly attained the motor skills of running around and the manipulations of early childhood. He was highly accessible to environmental stimuli, but had difficulty in narrowing his response. Both motor and mental impulses tended to irradiate. Great energy, an out-turning temperament, lack of body knowledge and intuition, and lack of understanding or *gestalt* formation in relation to the environment, combined to result in restlessness, incomplete activity and perseverance.

As he grew older, his uns subtlety became obvious and his unadaptability embarrassing. For 18 months he merely showed lack of adaptation in a benevolent though independent way. Then after the age of 6, when he started to learn, that is, began the cognitive organization of the confusion left by his somatic disorientation, his emotional level was retarded by at least 2 years.

At the time of his examination, the process of cognitive organization had proceeded so far that he could be regarded as no more than eccentric, but the problem still remaining was how to secure an equal advance in his social relationships. He

was already over age for his little nursery school. His over-intellectualizing mother felt his eccentricity as a severe strain. *Faute de mieux* he was sent to a small boarding school with a warm, permissive atmosphere. Here he thrived. His lively, good nature made him popular and he responded well to the school atmosphere where the interpersonal relationships were conducted at a low level of emotional tension. Meanwhile his intellectual reorientation continued, but it is doubtful whether James will ever sustain close, intimate, love relationships, or ever reach real intuition and understanding.

POVERTY OF RELATIONSHIP FORMATION

Robin S. (38) 6.4 years

Robin's behaviour raised problems of more acute social urgency, partly because of an added factor of social misfortune.

The problem was Robin's aggressive and destructive behaviour at home and at school. His mother said that he destroyed the furniture, tore the wallpaper, slashed upholstery with a razor blade, was noisy and restless, told lies and did furtive misdeeds. At school he attacked other children and had thrown his shoes at the teacher.

Mr. S. was a general handyman, a steady person, aged 56. Mrs. S. was 34 when Robin was born, housekeeper in a large West End house, in which they occupied a basement flat. Robin's sister aged 14 attended a central school; she had always been an exceptionally quiet and good child.

When Robin was conceived his parents were living in one room in a friend's house, and the pregnancy was a calamity. The birth was normal—9 lb. 2 oz.—but Mrs. S. was too frightened of breast abscesses to 'risk' breast feeding. By that time she had become the resident housekeeper in a house of medical consulting-rooms where she was 'not allowed to have a tiny baby'. Robin was sent at one month to a residential nursery, 80 miles away. His mother visited 'sometimes but not very often'. The matron reported that Robin seemed happy, was rather cheeky and had an enormous appetite. At 3, the nursery disbanded and Robin was transferred to a nursery 65 miles away. Mother visited infrequently. When he came home at 4½, he seemed cowed and listless and did not know how to play. He was sent at once to a day nursery, where he attacked the other children. At 5 he was in trouble at infants' school from the beginning, and at home his toilet training broke down. At 6 the wetting and soiling had ceased but he went to hospital for investigation of loss of weight.

Robin certainly appeared to be disturbed. His mother described him as restless and always on the go; he ate as much as a man; he forgot what he was told but sometimes would remind her about shopping and so on. She allowed that he got on well with his father and sister, but made no friends and did not know how to play. He needed showing how to make patterns with blocks, for instance, but then built the same pattern for days. She felt that she could not understand his needs, but added that she was not used to boys.

His headmistress said: 'It's just hopeless, I have nothing else to say: just hopeless. He is most aggressive, most spiteful, most dishonest, most destructive; and as for his language, it is most obscene.' He would not stay still, could not be trusted not to make a mess all over the chairs, or climb on tables and destroy things in cupboards.

He hit the other children and would pee over them. Punishment had no effect. He would do formal work only momentarily, when in the headmistress's room under threat of missing his dinner. 'There is no way in which one can appeal to him at all. I don't know what his mother is going to do with him, where to place him. It's just hopeless, I've never seen such a child in all my life—completely hopeless at such a young age.' Asking for his exclusion, she wrote: 'He is a complete nonconformist, aggressive, spiteful and ineducable in an ordinary school.'

Examination

At 6.4 years, Robin was undersized but with a clear complexion and a pale fine skin. Although most distractable he completed the R.S.B. Form L.—IQ 88. Poor memory but good manual dexterity. His speed of cerebration was remarkable and he was a prey to anything that caught his attention.

Robin looked like a little, pale, red-haired gnome, 2 years younger than his age. He came to the room willingly but had difficulty in negotiating stairs. He was extremely out-turning and distractable, running round the room, fingering each toy, asking questions about each object that he could have answered himself, had he looked. He seemed permanently excited. He used the doctor like any casual adult and saw no special significance in the occasion, unlike most 6-year-olds visiting hospital.

Much of his mother's worry was due to her embarrassment as a caretaker to a very old lady. He woke at crack of dawn and was active and noisy. If not locked in he would rush into the old lady's rooms and do awful things. He broke and hid a gold watch that his father was repairing for a friend. And so on, *ad infinitum*. A home visit revealed that she used to lock him in a tiny basement room, not much bigger than a cupboard, take away all movables and leave him with only soft toys. Robin had responded by the maximum possible urination and defæcation on the floor and wallpaper, and by picking holes in the plaster.

Comment

A report from the residential nursery where Robin lived from 3 to 4½ stated that he had seemed very backward on arrival and walked about with his hips and knees always in a bent position. He improved, but dragged one leg. (There was no neurological disability at 6½.)

It seems certain that Robin's placement in a residential nursery at one month was more because he was unwanted than forced upon Mrs. S. by the conditions of her employment. His apparent happiness at the first nursery was dangerously misleading, because later events showed that his adjustment was the impersonal one of a collectively brought up child in a formal patterned existence. He might not have been a problem provided that no major change occurred and that he was left in peace.

Change of nursery at 3 revealed Robin's poverty of relationship formation and inability to tolerate change. He regressed to toddler behaviour, with some obscure neurological difficulty. His behaviour was more characteristic of the severe depression of the toddler separated from his mother than that of a 3-year-old, and this itself may indicate his failure in instinct modification.

Robin's space orientation was complete before the change occurred and his

physical movements were reasonably sure, except for lack of confidence in negotiating some very awkward stairs. He lacked the refinements of character formation. At 4½, his super-ego was a rigid external framework of institutionalized behaviour. He could not tolerate delay in the satisfaction of his impulses, he had no internalized ideal, no understanding of 'good' and 'bad', other than the rules of the nursery.

His mother's kindness to him on his return ironically ended all hope of adjustment. Sudden exposure to emotional stimulation and satisfaction at a primitive level released his out-turning, hyperkinetic reaction pattern, previously damped down by depression. Life became impossible in the caretaker's flat, and off Robin went to a day nursery and from thence to school where he proved utterly unadaptable.

With his great poverty of emotional relationships, his weak ego and super-ego formation, Robin's plight was hopeless, as the head teacher said, until the basic love relationship could be established. Unlike Jacky H. (39) Robin showed little hostility but rather, complete lack of consideration, of understanding of social situations and how to behave; or even of recognizing the phenomenon of behaviour in any form—good, bad, or indifferent.

HYPERKINETIC, AFFECTIONLESS

Jacky H. (39) 5 years

The problems surrounding Jacky, as enumerated by his adoptive father, were 'tears wallpaper, urinates on wall; incurably interested in the "bottoms" of girls and women, lifts skirts and asks "rude" questions to such an extent that neighbours are cold shouldering the family; masturbates in bed; unable to play constructively; cruel to animals.'

Jacky's adoptive parents were a well-to-do couple living in a comfortable country home. Mr. H. was a business man, rather solemn and precise but with a strong sense of obligation. Mrs. H. seemed to have repressed all feeling, and to attempt to deal with her problems on an intellectual basis. The problems were too much for her.

They had a daughter 3 years older than Jacky, then after 2 still-births, they impulsively adopted Jacky at the age of 18 months, for fear of being left with an only child. A second girl was born 2½ years later.

Jacky had been abandoned at 5 months and after one month in hospital had lived in a residential nursery. At 18 months he was very backward and undersized, not walking and not feeding himself. From the first he showed remarkably little emotion, apart from being very demanding about food. At the children's home he was supposed to have been 'made much of'. He was passively compliant at first, learnt to walk by himself at about 24 months, and started talking at the same time. At this time, too, he would react to frustration by becoming stiff and resistant and occasionally, by a temper tantrum.

Jacky never developed an affectionate relationship with anybody. He took, superficially, to anyone new and people found him amusing at first. He never displayed any feeling about his parents but showed jealousy of the new baby in that he became more distractible and over-active and more backward in attainments. He started to dress himself only at 4½, was very poor with his hands and could not manage buttons at 5.

He went to the local village school at 4½, liked going, but did not get on well with

boys. The school report 6 months later was 'he is full of his own importance'.

Relationships in this home steadily deteriorated and when they came to the hospital, the parents were desperate. They felt they had done their best but were baffled. Mrs. H. was disgusted by Jacky's behaviour and felt that he 'ought not' to have turned out so appallingly badly. The impression left by her recital of complaints, which lasted more than an hour, was of a small but angelic-looking boy who, for several days on end, could behave like an angel but who would pass into unaccountable phases of difficult, even depraved behaviour. However kindly the adoptive parents had been originally, a vicious circle had been created by Jacky's unresponsiveness, which led, on his part, to unreliability and 'bad' behaviour, and on theirs to increasing sense of frustration and criticism of him that, in turn, provoked Jacky to hostility and aggression.

Examination

He was admitted to hospital for observation. At psychological examination Jacky was anxious and suspicious, distractable and caught at every excuse for leaving the table. He talked incessantly and tried to cut short the test. He was very unconfident in the verbal items, sometimes saying 'I can't' before hearing the instructions, which might account for much of his negative attitude. He was more confident in manual tasks. R.S.B. Form L. C.A. 4.11; M.A. 5.0; IQ 102.

Jacky looked angelic. Small, pink and fair, with curly hair and bright eyes, he could have modelled for 'Bubbles'. He was cheerful, friendly and responsive and greeted everyone with a smile; each newcomer thought what an adorable little boy he was, until they discovered that Jacky was heartless. He made no relationships.

In no time the serious aberration of his character formation was apparent. He was restless and extremely distractable, because his behaviour was purely impulsive and he exerted no self-control. He was amenable if watched all the time, and would obey an instruction for a few minutes. Alone in the ward, Jacky ignored the conventions of children's hospital behaviour, unless specially watched.

Jacky was not merely selfish; he did not realize the effects of his behaviour on other people, or even the possibility that his behaviour might affect others. Once he ran across the ward and jumped upon the bed of a big girl who was propped up, in heart failure. Half sitting on her, he took her book out of her hand and looked at it. Not finding it interesting, he jumped off and ran back, dropping the book on his way. All this happened before an outraged nurse could take action. Jacky was serene and unruffled; this was not a hostile act, but utterly thoughtless.

Though serene in mood Jacky showed much hostility of gesture. He threatened people with his fists and pushed other children, but apparently without feeling. If reproved he became abusive; but kindly attention excited him and made his behaviour even more unbearable. On the other hand he spent hours, quietly, looking at picture books. It seemed that it was an intimate home atmosphere that provoked his worst over-activity of a non-conforming type.

Humanity dictated his removal from home to a more neutral atmosphere but, as so often happens, once the parents had made up their minds that he must go, the home atmosphere deteriorated at once from desperate toleration under duress to cold, angry retribution.

Five months later Jacky went to a residential school for maladjusted children,

where his behaviour was impossible. He was transferred to a small home for delicate children where a nursery atmosphere was maintained.

He was extremely difficult at first, but after about 6 months he conformed better to the community life. Three years later the warden asked for advice because of occasional stealing, some nocturnal enuresis and occasional aggressiveness toward other children, and reported: 'He was certainly a difficult boy. Now he is not nearly so belligerent, he has learnt to mix with other boys. He shows affection and is not against the whole world. I think he will always need careful handling.'

Comment

Jacky was well orientated in space and movement; but his trouble could be identified in his absence of instinctual modification. He lived his life at a level of simple impulse gratification.

At 18 months his development was retarded to a level of, perhaps, 10 months and his passive acceptance of weaning had left none of the character-forming residuum that a mother might have stimulated. When he was adopted, familiarity with his new surroundings caused his passivity to pass off and his unmodified impulse life came to the fore.

At first he was no more than wayward and lacking rapport. His greediness could be controlled by feeding, but soon his activity provoked situations in which his lack of relationship made him, first, a nuisance and later, a menace to the home. His parents fell back on forestalling and attempting to frustrate his impulses, which stimulated Jacky to seek satisfaction and this being incomplete, led to perseveration of behaviour. His frustration led to hostile behaviour which, unlike that of normal children, was not directed against the whole personality of the opposition, but against the immediately frustrating agent, and was quite fragmentary.

Thus the behaviour developed that was observed in hospital. Newcomers always reacted to Jacky's angelic good looks, which stimulated his impulsiveness and this little angel would commit innumerable callous crimes with unruffled composure. The maddened adults would react punitively; and there could be no future in that vicious circle.

Interestingly, he reacted to the birth of his sister with the ego-centred jealousy of an unsatisfied toddler rather than that of a 4-year-old. Few parents would not resent an adopted child being jealous of their own child; but in fact this jealousy was a sign of a developing relationship which, though infantile, at least held some promise for the future. Unhappily the parents' punitive reaction, their fears about Jacky, nipped this developing relationship in the bud. Two years later Jacky was showing belatedly some oedipal difficulties, but behaviour that might pass unnoticed at 3 could be alarming at 6. Most of his bad behaviour was an anarchic reaction to frustration of unmodified impulses.

At the nursery home, in a tolerant regime, without moral responsibility and lacking close personal relationships, Jacky gained greater impulse satisfaction and was frustrated less. His behaviour quietened, and at 8 years he had the social capacity of a 5-year-old, with the misdemeanours characteristic of that age.

Although this quiet phase may last until adolescence, it is to be feared that the unmodified state of Jacky's impulse life, his weak ego and weaker super-ego will cause serious trouble later.

Four years after the last sentence was written, Mr. H. returned for further advice, Jacky being 13 years old and living at a residential home. Mr. H. had divorced his wife and was struggling to maintain a home for his two daughters. It appeared that the marriage had broken under Jacky's baleful influence.

Jacky had been removed from his nursery home because, with approaching adolescence they had felt he was becoming a danger to the younger children. He was also absconding frequently.

At his local authority senior boys' home he had appeared to settle down well and Mr. H. was urged to take him home, which was impossible for him to do. Then complaints of his behaviour began to be made by the Warden. Jacky was unreliable, friendless, dishonest, spiteful at times, and so on.

There could be little doubt that Jacky was an affectionless psychopath and would always be in need of supervision, however difficult that might be to provide.

Chapter 10

First-Year Psychosomatic Reaction Patterns

NEW-BORN babies reveal their emotional condition mainly by their bodily reactions, of which the most revealing are alimentary. Nervous parents of first babies commonly conduct a ceremony of weekly weighing and, on the whole, weight gain is a good index of thriving during the suckling period. When the child passes into the instinct modification, exploration and habit formation periods, various more specific feeding and habit difficulties may arise, which are commonly allied with somatic reactions.

DIARRHŒA AND VOMITING

The earliest and commonest somatic trouble associated with psychological disturbance is infantile diarrhœa. Suckling children whose care is interrupted, notoriously suffer from enteritis, the scourge of residential nurseries and emergency homes. Infection is usually prevalent, and these children are peculiarly susceptible. Some infants in the care of their mothers have repeated attacks of diarrhœa and rarely, as in the case of Aubrey B. (46), will develop ulcerative colitis at a very early age. Usually there is a long gap between the diarrhœa of infancy and the occurrence of ulceration around the age of puberty. Infantile diarrhœa engenders inordinate anxiety in some parents, and in this case tension will continue to surround the child's bowel functions. Clinicians are very familiar with the bowel-minded anxiety that pertains in those cases which go on to ulceration.

It is very rare for children's neurotic troubles to be referred to the upper end of the alimentary canal, with the exception of vomiting. The psychological significance of pyloric stenosis, if any, has not been determined, and there is no evidence that pyloric babies are prone to alimentary anxiety later. Gastric and duodenal ulcer are exceedingly rare and children rarely complain spontaneously of indigestion except, of course, after dietary indiscretion.

Vomiting has no certain psychological significance; it varies greatly from time to time and from child to child. It is commonest among those active children who bolt their food. Some babies will throw up a little of every feed, but this habit does not usually continue when solid food is taken.

PEPTIC ULCER

The genesis of the adult peptic ulcer syndrome is still uncertain and no

childhood condition has been shown to be relevant to it. The common recurrent stomach upsets of older children usually consist of periodic attacks of nausea and/or vomiting, migrainous headache, abdominal pain with or without pyrexia. They appear to be partly a matter of metabolic imbalance and will be discussed further in Part VI.

INFANTILE ECZEMA

The earliest serious somatic trouble of infancy with emotional sequelæ is eczema, which can be a terrible scourge. The psychological involvement will come from the nursing complications of the illness which may cause havoc in the child's developing relationships. It is exceedingly difficult for a mother to give herself whole-heartedly to the nursing of her eczematous baby, because of her deep, unreasoning horror of skin diseases, a horror that is as old or older than the ancient Hebrew leprosy regulations. Ointments, dyes, dressings, and paraphernalia generally will add to the inhibition of the mother's feelings. So, it is common for eczematous babies to be deprived of nursing warmth and to lie for hours without being handled.

The origin of infantile eczema is speculative; sometimes allergy is blamed, sometimes heredity. It should be borne in mind that both skin and brain are differentiated from embryonic ectoderm, so that there may be a direct connection between mental and skin troubles.

The later history of eczematous babies deprived of warm maternal nurture will depend partly upon the mother's capacity to compensate and partly upon the child's basic temperament. Out of various possible outcomes that have been described there is one almost specific type of reaction, that of the child who becomes progressively more tense and demanding, and who suffers his early instinct modification experiences with difficulty and impatience. Some of these children will become 'nervy', liable to sudden gusty tempers that suffer a greater or lesser degree of inhibition. A possible complication is asthma, or one of those night-time panic states variously known as night terror, laryngeal spasm or even croup.

ASTHMA

The actual route of development of asthma will be clear only in the case of a known allergy, but an association with infantile eczema is commonly clear. With or without an allergy, however, these children will commonly show a tense, striving quality of behaviour. They try very hard in all their new acquisitions and have a demanding, urgent attitude towards their parents. The toddler period is normally an age of striving; learning to walk and carrying things around are strenuous occupations and a toddler will spend much of his time in panting and puffing. Tenser children will try so hard that they go around puffing like a grampus; they will become breathless whenever frustrated or frightened. Night-time fears may set the stage for the onset of acute

attacks of breathlessness, recognized as nocturnal asthma. In later childhood the tenseness and the gallantry in difficulty of asthmatic children may be striking. Bronchitis is a constant accompaniment.

CARDIAC NEUROSIS

Among children with less natural energy or instinctual drive, breathlessness and anxiety may contribute to the emergence of an over-tired, neurasthenic type of syndrome, though there is usually a large element of adult suggestion when this condition develops during childhood. In particular the casual discovery of a heart murmur, followed by exercise precautions, may cause emotional havoc. It seems likely, though not proven, that 'effort syndrome' is a possible adult development in such cases.

HEADACHE

Among young children headache will occur only as a matter of supposition in the case of intracranial infection, irritation or trauma. It is reasonable to generalize that headaches occur rarely among children under the age of puberty, with the common exception of cyclical vomiting. Their occurrence will be almost invariably by suggestion from adults. Anxious mothers will say to the child: 'You look pale, dear; have you got a headache?' or mother's headaches may loom large in the family life.

It will have been noted that the psychosomatic illnesses of infants and young children are different in form from those of adults. In general the interaction of emotional states and bodily reactions is more clearly direct in the case of children and less subject to that cultural modification that is such a marked feature of adult psychosomatic illness.

VISUAL DEFECTS

Among somatic disorders with a potential bad effect upon psychological development, those of vision are most important, but have been neglected. The psychological difficulties of blind babies are too involved to be disposed of adequately here. It will suffice to note that the baby's visual *gestalt* of the mother is the most significant development of the third and fourth months of life, and it later supplants the baby's feeling *gestalt* in first importance. So the baby begins to understand what he sees and his orientation in space, which is of enormous importance to him, is dominated by vision.

If vision be absent, the child will be badly handicapped in space orientation and in body concept formation. It requires a high degree of maternal skill to compensate the baby for the absence of vision through the use of his remaining senses. A blind baby needs constant touch and movement, and without these, has little or nothing to work with. Too often blind babies will suffer neglect in relation to their needs. Any system is bad that will leave a totally blind baby unoccupied and out of sensory contact with his mother for more

than a very small proportion of his waking time. In any case it is difficult to prevent retardation of development in a blind child.

Paradoxically, a partially sighted baby may be worse off than the totally blind, because he may be distracted by light and shadow during the organization of his visual experiences. A 6-month-old partially sighted baby may lie in his cot, completely absorbed in passing and repassing his hands across his face, apparently watching a play of light and shadow in his visual field. This child, unlike a totally blind child may not give that meticulous attention to other sensory pathways that will be so necessary for his development and since his blindness is not suspected early on he will not receive extra maternal attention.

Four cases are recorded below (pages 221-8) of the effects of serious short-sightedness and long-sightedness undiscovered until late in childhood. The peculiarity of the short-sighted baby's situation is that he is surrounded at a little distance by a mist out of which moving objects will suddenly loom clearly and out of perspective. Little appears wrong until the baby begins to walk, for he will manage the earlier learning experiences satisfactorily; but as soon as he is mobile he may lose confidence, and become clinging and incompetent in wider relationships.

Contrariwise, the long-sighted baby is closely surrounded by mist and can only see clearly objects at arms' length or beyond, which will not help the orientation of a baby under 9 months. He has to remain dependent on hand and mouth for his orientation and so will appear babyish and backward. At worst he may fail to orient himself at a primitive level, and if his mother does not have a spontaneous urge to treat him more like a blind child, he may remain autistic and withdrawn, or hyperkinetic and unorientated.

DEAFNESS

The question of suspected deafness in a young child can seldom be settled with certainty until the child is capable of responding to 'peep-show' techniques of examination. The psychology of the deaf child is less explored even than that of the blind child and like the latter, should be studied as a subject in its own right. Here it will be noted that deafness is less likely than blindness to interfere with the formation of those basic infantile relationships that depend first upon alimentary and skin sensation and later upon vision. Even total deafness may pass unnoticed for a year, and if the child has become dependent and accustomed to watching the mother closely, deafness may not be suspected for 2 or even 3 years. However, the resulting speech backwardness will not go unnoticed.

Among deaf children there is nothing quite comparable with the blind child's need for tactile or auditory contact. Vision will enable the child's early relationships to develop quite well and it is only later when speech becomes important that difficulties will be inevitable. The deaf child's particular

form of difficulty will depend upon factors of temperament and environmental experience.

Reference has been made in Chapter 7 to the apparent deafness of children with primitive orientation difficulties. In these cases the deafness is hard to determine because although the child may hear sounds, he will not appreciate their significance. At their most abnormal, such children will not recognize the human voice as communication. For example it may occasionally happen that the mother will come back after a short absence and the child will look up at the click of the door latch and smile; on other occasions after a long silence he will look towards her when she calls his name. So the mother will be convinced that he is not deaf, though he may completely ignore her remarks for the rest of the day. Sometimes the child will respond appropriately to auditory stimuli, and at other times, not; it will be very baffling.

Some partially deaf but otherwise normal children will respond to sounds, but make little of speech. Their relationships will remain on an infantile, pre-speech level. Many factors are cited in explanation, including high-frequency deafness—a common phenomenon of doubtful practical significance, and congenital auditory imperception—which is merely a label to cover ætiological ignorance. What appears to be really at fault is the child's relationship system, for he does not perceive speech as signifying communication.

CLINICAL EXAMPLES

The problems that have been briefly discussed above can best be illustrated by case descriptions. In the case of asthma and eczema it will correspond more closely with clinical experience to take them together in the case illustrations. Often the clinical picture is mixed, with one or other aspect predominating at different times. In other cases only one aspect may show, but from the psychological point of view the differences between the two types may not be marked.

ASTHMA AND ECZEMA

Daisy P. (40) 12.5 years

Daisy lived with her parents, sister Linda aged 8.5 and maternal grandmother, above Mr. P.'s public house. Mrs. P. helped in the bar. When she was 4, Daisy developed asthma following whooping cough. Attacks came about once a month and lasted several days. They were severe enough to make her sit up for hours because of breathlessness. The onset was usually at night. Attacks were often associated with excitement; Mrs. P. thought that some of her wheezing attacks were put on to get attention. 'It's all jealousy of Linda,' she said, 'she'll sometimes produce an attack when I come in in the evenings.'

The mother was also critical of Daisy's tempers and rudeness, and resented her apologies after an outburst. 'She can turn on the tap to order.'

Normal pregnancy, Cæsarean birth because of suspected disproportion; no early

troubles; breast fed to 8 months; easy weaning; all developmental milestones were passed early.

The mother's description of Daisy's later childhood was in complete contrast. Daisy was greedy, her overeating caused overweight and she would not diet. She reacted unfavourably to all changes, could be sweet at times, but at other times was intolerably rude and said dreadful things. Mrs. P. said 'I am sorry for her sometimes, no one wants her. She was such a cry baby and cried at the least little thing.'

It seemed that the grandmother had most to do with Daisy. Her fourth birthday marked a turning point; previously, there had been little difficulty other than greediness and inability to take change or excitement. Eleven days later Linda was born; 2 months later Daisy started school, and one month later still, contracted whooping cough, from which the asthma developed.

Relations between the sisters were poor. Mrs. P. said that Linda was good, sweet, tidy, saved her money, a good scholar, but faddy with her food. Daisy was disagreeable, domineering, stubborn, untidy, profligate, backward at school, and greedy; a creature of short-lived enthusiasms, boastful and not too truthful. She teased, bullied and exploited Linda.

At first Daisy screamed so violently at school that the mother asked an aunt to take her there because she felt too upset herself. Later, Daisy settled down, made friends and gained a central school place.

As well as having attacks of asthma Daisy made a great fuss if she hurt herself. At 5 she reacted by tenseness and inhibition to a week in hospital for tonsillectomy.

Her ambition was to be a dressmaker but she never sewed at home and was not good at it.

Examination

R.S.B. Form L. IQ 103. She had a wide scatter, showed anxiety about her performance and was easily discouraged.

Daisy was a large, lumpy girl, clumsy and awkward, considerably overweight. She was talkative and spoke with a lisp. She described how she would try to ward off asthma by auto-suggestion, but did not often succeed. Of Linda, she said: 'Well, she is thin and she has had measles. Oh! and she has just been run over and has broken her collar-bone. We have our usual fights,' adding with a laugh, 'when she has got a lot of money, then I agree with her.'

Her ambitions were to be a dressmaker, an air hostess, or a hairdresser; 'I'd like to be a nurse, only I'd faint at the sight of blood.' Asked to name three wishes, she said (1) health, (2) happiness, and (3) 'this one's silly but I would like Mummy and Daddy to win a football pool and then we could have commercial TV. Mummy won't have commercial now, we've got to go to bed at night.'

At this interview Mrs. P. was at some pains to correct an earlier wrong impression. Daisy had improved lately because Mrs. P. had made less fuss of her. Even the asthma attacks had fallen to about one every 6 months.

Comment

Daisy was striving, dissatisfied, and given to self-compensation; cross, disagreeable, suspicious of change, jealous, easily offended, and greedy. Her infantile relationship formation was unexceptionable, but after weaning, Mrs. P. had withdrawn from

the first place in Daisy's life in favour of the grandmother, who evidently had failed to satisfy Daisy. The child continued demanding and striving after her mother.

Linda's birth and Daisy's first attendance at school inflamed her insecurity. Whooping cough completed her discomfiture, and was the trigger of her attacks of bronchial spasm. Daisy's personality caused her, tensely, to try to overcome her difficulties.

Subsequently Mrs. P. was torn between anxiety at having to combine sick nursing with care of a young baby and her work in the public house; and resentment over Daisy's disagreeable nature. She compensated by over-evaluating Linda who was 'good' (but also timid, dependent and a poor eater). Paradoxically, it was the asthmatic Daisy who eventually settled down, made friends, was popular and gained a central school place in spite of only average intelligence.

Mrs. P. proved able spontaneously to recognize where the family relationships were drifting and to modify much of her attitude. Though things improved, the father remained rather remote and it was never clear whether their new-found family peace was that of neutrality or of enriched relationships.

John H. (41) 2.6 years

John was referred for severe feeding difficulties, underweight, occasional bouts of asthma and recurrent bronchitis. He was the adopted child of harmonious parents. Father was a commercial traveller, easy-going, and friendly. Mother had been a children's nanny, married at 30, and her sterility after 5 years of marriage had been insupportable. They lived in 2 rooms in the maternal grandparents' house, over a shop and with no garden.

John was adopted through a registered society, at 6 weeks, in good health. The natural father was an Air Force officer, and the mother 'a girl of good family'.

Mrs. H. had been trained in a rigid schedule school of baby care; she fed John fussily by the clock. John's response lacked vigour, feeds were prolonged, and he took disappointingly little. His slow weight gain caused her to try every food she could think of.

At 6 months, a sharp attack of infantile eczema forced Mrs. H. to abandon her routine, and John himself was cross and demanding. The family doctor blamed milk allergy and recommended weaning on to solids. Mrs. H. was ill equipped to deal with the resulting conflict. John refused the spoon and clamoured for the bottle, which the mother believed was the cause of his disgusting skin disease.

Mrs. H. reacted by over-control and superhuman patience to John's uncontrollable rages. After 2 months, the rages burned out, and left John quiet but tensely refusing food. Mealtimes became like a war of attrition and dominated the household life. Mrs. H. was terribly worried that he weighed only 19 lb. at 2 years.

As a toddler, John was dour and over-controlled, busying himself in exploration and keeping remote from his mother. Motor development was average. After weaning his sleep became disturbed, occasional night terrors appeared at 14 months and at 15 months his first attack of asthma occurred during a bout of recurrent bronchitis. During the next 2 years asthma occurred irregularly at night, often preceded by wheeziness and sometimes by bronchitis. Attacks lasted for about one day and could be relieved by antispasmodics.

At 2½ asthma investigations gave indecisive results. The eczema had cleared up.

When seen at the hospital, John resisted separation from his mother and stood for some time clutching her skirt, looking dour and unfriendly. Subsequently he attended with his mother at roughly monthly intervals, and nearly a year elapsed before he was heard to speak.

John slowly thawed out and would allow his mother to go into another room. He handled toys deftly, and became absorbed in quite imaginative play. His mother, meanwhile, discussed the war of attrition with great emotion. It needed all possible support to enable her to put up with his food refusal.

Mrs. H. was full of doubts and self questionings, she was able but had had rigid training. None of her charges had been difficult, so why was John? Was it her own influence? Was he 'bad stock'? She thought they had overdone keeping him quiet for the sake of the old people beneath; but John was a noisy child.

From Mrs. H.'s account, John was certainly a starving child, but he gained weight slowly and enjoyed good health. His asthma slowly lessened in frequency and intensity. His mother insisted that there was no improvement, but about a year later she talked of adopting a baby sister for John, though she feared an explosion of jealousy from John. Throughout the next winter, John had no asthmatic attacks, and although she remained gloomy about his appetite, she was regaining her nerve.

Carol was adopted at 6 weeks, shortly after John's fourth birthday. She was an easy, placid baby. Mrs. H. involved John in looking after Carol. He seemed interested in and pleased with her, but suffered an increase of mealtime tension and a sharp attack of asthma. Mrs. H. was not unduly daunted.

At 4½ John started at a nursery class and became withdrawn for a while. After 6 months he was mixing better, but being aggressive and having frequent temper tantrums. He was eating well at school, but no better at home.

At 5½ Mrs. H. reported maintained improvement and no worries about feeding, though 'some days he doesn't eat enough to keep a fly alive'. Attacks of asthma were reduced to one every 6 months. Carol was overweight, a fat, placid toddler who, her mother thought, 'showed up' John. His intelligence was average: R.S.B. Form L. IQ 110. He appeared still to be a dour child, tense and unrelaxing, slow to unbend, active but withdrawn; but there was no doubt about his ultimately good capacity to adjust.

Comment

There is nearly always some doubt about the heredity of adopted children, and there is no evidence in John's case. The first difficulty arose from Mrs. H.'s excessive expectations about the amount of food she thought he should take. She restlessly changed his feeds and the eczema, which may have resulted from the changes, seriously impaired her capacity to nurse John. The crisis came with the ill-advised early weaning which provoked terrible, uncontrollable aggressive feelings in John, which he inhibited, and he withdrew as far as possible from the painful feeding situation. His mother subjected him to such anxious pressure that a state of war developed which was all the more poignant because both parties were affectionate. John's turbulent, hostile feelings, over-controlled by day, began to emerge at night in the form of panic states. His striving nature and a possible allergy were other factors in the development of asthma.

In some respects the asthmatic attacks were a safety-valve, as it were, a cathartic

experience for both parties, whose feelings of guilt might find some expiation in suffering endured mutually.

Slowly, and imperceptibly to the mother, the intensity of the feeding difficulty lessened, but recovery was slow because of John's inhibition. He slowly made a relationship with his father also, but he remained so dour that his mother failed to appreciate his recovery. John's reception of his newly adopted sister was saturnine, but was his warmest and most spontaneous reaction up to that time; and he also made quite a quick adjustment to school but, as when his sister arrived, a temporary setback masked his real all-round improvement.

The prognosis was good, though John will always be dour.

Gladys N. (42) 9½ years

Gladys also was a tense, striving child, though compared with John H. (41), her somatic difficulties were less in her respiratory system. She was referred because of her inability to read, a stammer, general nervousness and a tendency to panic.

Gladys had a brother and a sister, 10 and 9 years older. She had been wanted; pregnancy and confinement normal. Her mother's milk dried up at 3 weeks but Gladys remained easy and placid. At 4 months she developed a bad cough, lost weight and screamed incessantly. After prolonged treatment, the cough improved but some wheeziness remained and she did not fully regain her appetite until 2 years old.

Motor development was forward, dry and clean by 12 months but she still wet her bed very occasionally, to her intense shame. Gladys screamed when sat in a bath, until 8 years old, and never went to sleep without her mother holding her hand. She was always prone to coughs and catarrh and looked 'washed out'.

Up to 2.10 years they lived, in a strained atmosphere, in the grandparents' house. Family life was stable except for a protracted quarrel between Mr. N. and his father whose shop he managed. When Gladys was 5 the quarrel terminated in the father leaving the grandfather's employment.

Gladys's first year at school was greatly interrupted by illness. She was frightened and at 9 years still had to be escorted by her mother. Her behaviour was subdued and good, and her progress poor; she could not read.

Mrs. N. was affectionate, but a driving, anxious person who talked non-stop about her worries. It was clear that the boy, then 19, was unusually dependent on her.

Examination

R.S.B. Form L. IQ 102. Reading 3 years retarded. Projection testing revealed a guilty attitude and strong identification with the mother figure.

Clinically, Gladys was tense and dependent but talked freely although with some hesitancy. After some indecision she chose to play with coloured sticks, with which she made intricate and obsessional patterns. Her movements were neat, deft, careful and tidy.

Gladys attended for remedial reading during 2 terms and gained confidence, but became very dependent on the psychologist. Her headmaster then reported that she was no longer a problem though her Reading Age gained only a very few months. Treatment continues.

Comment

Gladys had an in-turning temperament and her reaction fell between the tense striving typical of the asthmatic and the passive anxiety of the colitis subject. Though subdued she was not ineffective. People liked her, she made friends; and apart from reading, she got on well at school. Two trigger factors deserve consideration: first, an allergic rhinitis that made a misery of her later infancy, and disturbed her weight curve by embarrassing her in breathing and feeding. A more striving child might have suffered a frenzy of frustration and breathing difficulty. Gladys's more passive attitude carried her through with merely proneness to colds and catarrh, but with tenseness later, and sleeping difficulties.

The second factor was that her mother strove more than enough for mother and daughter together, in a way that augmented both Gladys's tenseness and her dependency. As she grew away from her mother, in school and elsewhere, her modest capacity for independence could be seen.

Hilda N. (43) 11.9 years

Hilda was generally dreamy and idle at school, unco-operative at home, discontented and fussy about even the most trivial matters.

Hilda lived with her parents and 16-year-old sister, Sue, in a comfortable suburban house. Her father was a retired tea planter in Assam and Hilda's early history had been very chequered indeed. War had disrupted their family life; stopped home leave; the Japanese invasion had meant evacuations and separations.

Pregnancy and confinement were normal but took place 1,000 miles away from home. Breast feeding failed because of the mother's depressed nipples. Bottle feeding was difficult to establish, Hilda screamed excessively at night. At 3 months the mother and Hilda rejoined father (and Sue) for 9 months, then the mother had a 'nervous breakdown'. Sue lived away with relatives continuously for 2½ years. Mrs. N. stayed away with Hilda in Northern India for 18 months, then rejoined the father for one year, when they all (Sue included) returned to England. When Hilda was 4, Mr. and Mrs. N. went back to Assam leaving Hilda and Sue in a boarding school, and with an aunt for the holidays. At 5½, Mrs. N. visited for a few months. At 7½, the complete family lived for a year with the maternal grandparents and then moved to their suburban house, the children attending day school.

Mrs. N. thought that Hilda had been placid as a small child, and tolerated being left, without making a fuss. Poor eating was so common among English children in India that little was thought about it. Her mother first thought of Hilda as being 'shut-in' on seeing her again at 5½ after 18 months' absence.

From early days Hilda had had attacks of acute bronchitis and wheezing, not amounting to asthma, but tightness across the chest and breathlessness. When at boarding school at 4, she developed eczema which remained, off and on—scaly patches on the flexures of knees and elbows, and behind the ears, occasionally weeping.

Mrs. N. was cyclothymic and out-turning, voluble but unsubtle, one of 17 children herself, and conditioned by sibling pressure to conceal her feelings, which were unusually powerful. At times she was almost manic in her drive and energy. She could not tolerate 'sloppiness'. She was undemonstrative to her children but ex-

tremely attached to the father, who came from a Scottish working-class home, through university by scholarship. He was competent, practical, reserved and materialistic. Sue was described as 'scatterbrained and volatile'; there was more rivalry than companionship between the sisters.

The complaints about Hilda were that she was dreamy, 'mooned about', 'very selfish and egoistical'; an adept at avoiding difficulty and responsibility and at putting on an 'I'm only a little girl' act. She had no friends and played only with much younger children.

Her one passion was for horses and she would work hard to earn money for an hour's riding. She made friends with the owner of a nearby riding stables who welcomed her help in mucking out the stables.

Hilda's school joined the chorus; 'poor work, she must make more effort'. 'She needs to adopt a much more energetic outlook both in work and play.' 'In class she will either dream or clown and the other girls look upon her as a complete fool.' 'She would be teachable if only she would make the effort.'

Examination

Her intelligence was superior. R.S.B. Form L. IQ 136. Her approach was timid and tense, but she tried hard. Her verbal responses were of outstandingly good quality

At 11.9 years, Hilda was mature looking, pretty, with engaging manners and charm. Though passive, she gave information readily in reply to questions but said nothing spontaneously. She was enthusiastic only about horses, and her face lit up when she talked about her all too rare rides. She seemed passively to accept the constant criticisms made of her. She could not describe how she spent her time, and it was not part of her scheme of things to be 'doing something'. She read a lot and kept a scrapbook of the Queen.

At this time, Mrs. N. complained tensely about Hilda's laziness, 'both mental and physical; if you make a terrible fuss you can get her to do things'. She rejected an opinion that Hilda was attractive and remarked disapprovingly that 'people outside the family like her', as if this were some deceitful trick of Hilda's. Hilda lived in a dream, 'she's as much trouble to look after as a 6-month-old baby'. After this Mrs. N. said, self-revealingly: 'I feel she has no armour against the world; she just lets life hit her and pass on.'

Treatment had to be delayed 6 months, owing to pressure of work, and the mother became even more desperate. 'She failed every exam at school, quite happily, not a bit abashed. I really think she is stupid, she's so slow. It's an awful strain prodding someone all the time, she fiddles her time away, she has no concentration and can't apply her knowledge.'

Hilda was growing, and developing rapidly, physically. She attended regularly each week for treatment. She was friendly and passive, but her tendency to dissociate and to sit vacant with a little smile on her face raised fears of schizophrenia, which happily proved unfounded. She developed an interest in chess at which she concentrated and applied herself well. From this modest beginning to enhancement of self-respect necessitated a long treatment period, not the least part of which was the attempt to reconcile the parents with their own turbulent feelings about their disappointing daughter. In due course Hilda obtained a respectable G.C.E. 'O' level result, but although greatly improved in her human relationships, she still

preferred horses to humans (Hilda's treatment will be discussed further in Chapter 19, pages 448-9).

Comment

Hilda's temperament was in-turning but in spite of her chequered early years she had strong and durable basic love relationships. The infant period, before the mother's 'nervous breakdown', must have been satisfactory. As a toddler, however, Hilda reacted sharply to her mother's depression. She was a girl of strong feelings and she inhibited to an extent that seriously impaired her capacity to make an effort.

This inhibited, though striving, reaction resulted in wheezing bronchitis rather than in asthma. When abandoned at 4 with her 8-year-old sister, Hilda went into her shell and inhibited, unable either to make social relationships or to learn, though it is inhuman to demand academic learning of a separated 4-year-old.

People were kind to Hilda who was 'a sweet little thing', but much of her 'sweetness' was due to a general state of inhibition. Hilda was a severe disappointment to her parents on their return when she was 7, because she displayed the antithesis of their highest values, of industry, determination and initiative. Their guilt over their enforced neglect of the children made them blind to her difficulties.

From then on Hilda was a marked girl—'stupid, dreamy', etc. Sue, equally a disappointment to her parents, was more out-turning and became flighty and distractible. Hilda lived up to her reputation; though she was of superior intelligence, her school record was quite indifferent; incompetent in contemporary relationships, she turned to horses, a common happening among in-turning adolescent girls.

Hilda's trouble cannot have been inevitable. Her basic relationships were sound, she withstood severe deprivation experiences at a dangerous period in childhood, with only mild psychosomatic effects. With understanding at home, all could have been well. (See also *Bernard P.* (50).)

DIARRHOEA

It has been remarked that young infants tend to react to privation by diarrhoea, that 'D & V' is the great institutional scourge of infancy. The susceptibility of infants to bowel upsets is notorious; and the worry of parents about diarrhoea—their feverish attempts to correct it and the resulting disturbances of family life are likewise notorious.

Shirley P. (44) 22 months

Shirley's diarrhoea and vomiting attacks had begun at 6 or 7 months, and had increased in severity from 9 months. Since being taken off the breast at 6 months she had screamed, refused the spoon, brought back mouthfuls, and, her mother said: 'holding the feed in her mouth and staring at me defiantly'.

Shirley lived with her parents and 5-year-old sister, her father being an R.A.F. flight sergeant who was away from home for 2 nights each week. He was a kindly sensitive man who supplied something of the mothering that the mother was unable to give. The mother, aged 27, described herself as having a bitter attitude to life and very self-conscious. Since witnessing an aircraft accident when 13, she had suffered

from attacks of twitching of the arms, several times a day, each attack lasting perhaps half an hour. They varied in intensity, being worse before menstruation. Bad attacks made her feel wretched and irritable; once she had dropped Shirley and was nervous of holding her babies. For the same reason she hated going out. There was no discoverable organic cause for this peculiar malady.

Pregnancy and confinement normal, and all went well for 6 months. Then Shirley was taken off the breast, but refused a rubber teat for 2 days, until one was found with an unusually big hole. At 7 months the diarrhoea first appeared. She refused solids for some weeks, and still insisted on a night bottle at 22 months. Feeding remained intermittently a source of strife.

Teething was early, but she was not walking independently by 22 months. Talking was forward, she could put two words together. Toilet training since birth, she was clean, but not dry by night.

More serious diarrhoea at 9 months coincided with a longer absence of the father, and a change of house. Shirley lost a good deal of weight, and was admitted to hospital at 22 months. Her mother was too nervous to make the 25-mile journey alone, and father could visit only once a week.

After Shirley had spent 10 days in hospital and before her parents' second visit, she was sitting upright in a cot, motionless and with the fixed morose expression of the deprived child. When touched she burst out into bitter sobbing cries, and when picked up seemed inconsolable. Laid across the doctor's shoulder and held firmly, she lay inertly for several minutes. She looked at her parents as they came in, but made no sign. She sat passively erect on her father's arm, accepted several 'Smarties' and ate them voraciously. He put the box on the table and she whimpered and pointed at the sweets. He said firmly: 'No, that's quite enough for now', to the distress of the doctor, since Shirley had refused all food for 48 hours. F/Sgt. P. devoted his major attention to her, whereas her mother sat passively not even touching Shirley, leaving it all to her husband.

Shirley was so disturbed that she was discharged home at once and both parents were exhorted to make much of her, with some success. Shirley gave up the night bottle, and also walked by herself soon after her return home. She also exhibited much more active emotion at mealtimes. Instead of passive screaming and refusal she had temper outbursts, seizing the spoon and fending for herself. This, though trying and alarming for the mother was a great advance.

Comment

As compared with the asthma/bronchitis children, Shirley was very passive, almost feeble. Her obduracy over feeding was only a passive declining to swallow or to use a spoon. Apparently, Mrs. P.'s fears over her twitching arms had made her unable to give real body comfort to her suckling infant. Sudden abandoning of breast feeding at 6 months caused Shirley to refuse the teat, and was followed by diarrhoea. The father supplied something of the mother's deficiency but when he went away on duty at 9 months Shirley's diarrhoea became serious and chronic. The mother apparently failed again and Shirley passively resisted not only weaning, but also acquiring clean habits, and to an even greater degree, walking. Yet her talking was forward and her relationships otherwise well developed. She was normally a friendly, responsive child.

She broke down completely in hospital, would not eat and showed a deprivation reaction typical of a child of half her age. Her diarrhoea was a primitive anxiety reaction set in a generally timid and emotionally retarded style of life.

INFANTILE DIARRHOEA—LATER SICK HEADACHES

William J. (45) 10 years

Willy's mother complained of his recurrent sick headaches, irritability and 'inferior' complex.

The family lived in poor circumstances in a wretched 3-roomed flat. The father, aged 57, had been an army pensioner for 10 years through arthritis, and 3 years before had had coronary thrombosis.

The mother was 47, and had had much ill health. Willy had a sister of 11 years, a brother of 9½, and sisters of 6 and 3.

Mrs. J. had been worried by conceiving again only 2 months after the birth of her first baby. At that time they were living in one furnished room. Birth was 3 weeks premature and the mother did not see Willy for 7 days. Breast feeding failed, and no bottle feed suited him; he had persistent diarrhoea for 8 months, when Mr. J. cured the bowel trouble with milk chocolate. Willy weaned easily on to solid food.

After a sharp attack of measles at 12 months and again when his mother was away for the birth of his brother by Cæsarian section at 18 months, Willy fretted and had diarrhoea. At 3 years he was upset by having both legs encased in plaster from thigh to ankle for 6 weeks.

At 4 years he was quarantined in hospital for 6 weeks and never forgave his parents for not visiting. He was timid at school, unable to stand up for himself, made no friends and was unconfident in his approach to learning.

His sick headaches came on when he went to school, first every few months, but recently almost weekly. His appetite was good, especially for carbohydrates. He had worn spectacles for short-sightedness since 4 years of age.

The birth of his youngest sister, at 6½, made no appreciable difference. At 7½, Mr. J. started heart attacks, which became a major influence on their family life. Mr. J. was a very anxious person, a psychiatric casualty of both World Wars, obsessional, inhibited and worrying.

Though Mrs. J. was a warm, competent person who jollied her weaker relatives, she tended to smother them and, like her husband, found aggression very hard to tolerate.

Mrs. J. described Willy's personality as reserved, defensive, concerned about his appearance, and 'prim and proper'. He worried about many things and especially about any 'scene' or unpleasantness. He was jealous of his younger brother, but passive, and a doormat. He was moderate in attainment at school, anxious to do the 'right thing', timid, and could not tolerate roughness. The members of this family had little social life.

Examination

R.S.B. Form L. IQ 89. Schonell Word Recognition R.A. 6.2 years. On Raven's Controlled Projection Test he showed little imaginative activity. W.I.S.C. Performance IQ 110. He needed much encouragement but his responses in performance tests contrasted strongly with his timidity in verbal items.

Willy was a tall well-built boy, with very thick concave spectacles, a dependent manner, inhibited, tense, nervous and over-controlled. His speech was lisping and indistinct. When asked what part of Canada his father had come from, he said 'U.S. I think it is'. He did little more than poke at the toys gingerly with one finger, pick them up, look at them and put them down again with a minimum of movement. He showed some spontaneous rapport.

At this time, although his bowels had always been loose, the whole family tended to revolve around his recurrent headaches. He caused panic by remarking: 'I'm scared of going to sleep, because I might not wake up again.'

His headmaster, a warm and hearty Irishman, said: 'Both Willy and his sister are weak willed. Willy bursts into tears when you so much as look at him. He has no guts, no backbone, but he is better than he was.'

His mother was too anxious to co-operate well with phenobarbitone treatment, but achieved some confidence in the control of his headaches by caffeine and ergot, and things improved. Both Willy and his mother gained a more confident attitude to life.

Comment

Willy's difficulties were an accumulation rather than specific. He reacted to infancy feeding frustration with persistent diarrhoea, regression and dependency. Measles at 12 months, his brother's birth at 18 months and orthopaedic treatment at 3 years confirmed this threefold reaction pattern. A new element appeared at 4 years when he became angry with his mother for not visiting him in hospital, but neither he nor his family could tolerate aggressivity, so he inhibited.

Though his sick headaches came on when he went to school his eyesight was not questioned until 3 years later. After 12 months' wear, he had become completely dependent on his glasses and even wore them asleep. He could not distinguish letters without them. Naturally, he had made no progress in reading and was extremely uncertain in all verbal learning. Worry, eyestrain and headache followed and the last-named was not cured by spectacles.

Cases (50)-(52) will illustrate further some other orientation difficulties resulting from visual handicaps of young babies. The short-sighted baby lives in a narrow belt of clear vision, surrounded by mist and obscurities in middle distances and further. During the suckling period this may not greatly matter—but unfortunately Willy suffered frustration, and passed into the era of space exploration with impaired confidence in his mother. He had the short-sighted toddler's further difficulty in seeing things in perspective, and tendency to be timorous and retarded in emotional development.

Willy had the typical passive unadventurousness of those children who develop diarrhoea in infancy, but his difficulty owed most to emotional regression following upon the combination of childhood disasters. His mother's maternal capacity was overburdened with a neurotic husband and ailing children. When Willy regained the use of vision, his competent intelligence helped him to rehabilitate.

With the help of the hospital to contain parental anxiety and to reduce inappropriate pressure, two years later Willy was doing well, except for occasional headaches.

ULCERATIVE COLITIS

Although diarrhoea is the standard way in which babies react to anxiety, and commonly becomes chronic, yet ulceration is rarely diagnosed. Possibly it might be found more often if looked for. Ulcerative colitis in a child is a serious, disabling disease that may cause a crippling family anxiety, and expose the child to permanent invalidism. On the somatic side, there is danger of development of a rigid fibrous colon, further ulceration and perforation, malnutrition and vitamin deficiency. It is very important for child psychiatrist and pædiatrician to work in close co-operation on these cases.

Aubrey B. (46) 4½ years

Aubrey was first seen in hospital, as a case of chronic, relapsed, ulcerative colitis.

Prior to his admission to hospital at 4½, Aubrey had been passing 3 to 4 loose motions per day, with occasional blood and much mucus. For Aubrey to have a formed motion was an event in which the whole family rejoiced. He had become very used to hospital and complained very little when admitted.

Aubrey lived with his parents and sister 20 months younger, in a small country cottage. The maternal grandmother lived nearby and was very important to the family. Mrs. B. was tense and anxious and, at this time, she was unfriendly, critical of attempts to help, and complaining of real or fancied mismanagement of her problem. She was very grudging of information. Mr. B. was a skilled artisan, and it seemed that the marriage relationship was satisfactory; but he rarely came near the hospital. Aubrey's sister seemed to be a healthy and successful little girl.

Pregnancy and confinement normal; breast fed to 6 months and, apart from miserable housing, his mother maintained that all was well. Much later, in a rare moment of unbending, Mrs. B. said that she had first suspected blood and mucus in his stools at about 5 months, but had been too frightened to mention it. At 8 months he had an operation for *fistula in ano* but this had not been considered serious.

Feeding adhered to schedule, he was 'a good baby on the whole but was very naughty with his teething and gave us a lot of sleepless nights'. He appears to have been an ailing child, passively miserable and babyish, late in developmental landmarks. His bowels continued to be loose; at 18 months he was 'particularly low' and at 2 years he returned to hospital for 10 days, with blood and mucus in his stools. He was considered to be undernourished and in poor condition. He improved on a low residue diet, but relapsed later and had another 10 days in hospital at 3 years.

When older, he rarely played with other children, ostensibly because of his bowel frequency. He was 'good' about food, often enquiring whether something would hurt his tummy. He had a poor appetite, sometimes complained of pain. 'When he is feeling really poorly he likes the family out of the way and wants to be alone. But on the whole he is a very cheerful child and gets on well with grown-ups and other children. He isn't at all timid, in fact he is quite tough and can certainly stand up for himself.' The fact was that Aubrey had little or no experience of playing with other children.

Surgical investigations at 4½ showed that the sigmoid colon had been reduced to a fibrous, rigid passage. The indication was to excise the diseased portion, and maintain an ileostomy for about 6 months. What were the psychiatric indications as to timing?

Examination at 4½ years

Aubrey could have passed for 3 years old. He was pale, not poorly nourished, subdued but not distressed, perhaps over-controlled. He slept well, gave no trouble, but had a poor appetite. He sat up in his cot listlessly; had practically no relations with other children in the ward, but talked freely with adults about his illness.

Evidently Aubrey's illness had so affected the whole family that a life of invalidism, seclusion and over-dependence was forced upon him. Emotionally he was as dependent as an infant upon his mother. Psychosexual differentiation was likewise retarded. His over-controlled behaviour, over-goodness and inhibition of aggression indicated a severe fixation at an anal level. He was of out-turning temperament but severely inhibited.

Cortisone was not available at this time, and the question was, when should the operation be performed? Immediate operation was recommended on the triple consideration that Aubrey was already well adjusted in hospital; it was desirable to close the ileostomy period before he went to school; and it would be better to clear up this bowel trouble while he was still in an anal phase of psychological development, for with the current family preoccupation he was unlikely to develop further into an oedipal phase.

Subsequent investigation showed that the disease was so extensive that there was little chance of re-establishing a functioning anus after ileostomy. The operation was shelved, Aubrey went home, and an attempt was made by counselling to get his mother to modify family life.

Six months later Aubrey was well, but having 3 to 4 bowel motions daily, free from blood. Ten months later he was still well, but infantile and clinging, and his mother would not let him go to school, though he was 6 months over school entry age.

Because of Mrs. B.'s attitude it was decided to test Aubrey's intelligence. R.S.B. Form L. C.A. 5.7; M.A. 4.0; IQ 72. P.R. 1-2. His poor application and very short scatter suggested inhibition. He would not leave his mother's side and his apprehensiveness probably affected his test result. His mother, defensive as ever, explained that Aubrey had been very much better, on the whole more independent and having less bowel trouble. However, about 5 days earlier she, herself, had developed an axillary abscess. Aubrey was worried, refused his dinner and started having 5 or 6 bowel actions per day. Aubrey's diarrhoea persisted after her condition cleared up and his buttocks become excoriated. The diarrhoea improved, but one month later blood appeared in his stools for the first time for more than a year.

One month later still Aubrey was readmitted to hospital with *fistula in ano*, and further psychological tests were given. Vineland Social Maturity Scale, Social Quotient—65. Allowing for Aubrey's lack of opportunity to acquire social skills his level of social competence in a group of children would be no more than that of an average 4-year-old. Merrill Palmer Scale: C.A. 5.9; M.A. 4.10; P.R. 1-4. He showed a similar lack of persistence as in his earlier tests. Bellak's Children's Apper-

ception Test revealed a very literal-minded boy with a certain security in benign parent figures and some subdued natural aggressiveness.

Aubrey recovered quickly and was discharged home and after parental hesitation started at a local infants' school at the age of 6.1 years, mornings only. He went to school passively, but 3 weeks later was readmitted to hospital with a recurrence of *fistula in ano*. Mrs. B. admitted that it had never really cleared up. Aubrey remained in hospital for one month, and returned to school without difficulty.

All went well for a while. At 6½ it was reported that he liked school and wanted to attend all day, the difficulty being his low residue diet, which necessitated dinner at home, too far away to walk. The diet was modified and Aubrey spent all day at school.

For a whole year, favourable reports continued. It was touch and go whether he was not better suited to a school for educationally subnormal children, but he held his own, more or less. Then, unbelievably, Aubrey was readmitted to hospital (aged 7.6) with a head injury, as a result of a fight at school! He had been pushed in a skirmish which he had started, and fell, striking his head on a bench. It was typical of his mother to rush him to hospital for a black eye, and he was admitted for old times' sake. He stayed for one week, was cheerful and composed and showed a far greater capacity to enjoy hospital life. It was thought that he had matured considerably.

The school medical officer was worried by reports that Aubrey was aggressive, a poor mixer and of border-line intelligence and, very justifiably, raised again the question of E.S.N. education. He was advised that Aubrey's aggressiveness was a sign of some recovery from inhibition.

We had failed to reckon with Aubrey's mother. She had long accepted the hospital and was easy, friendly, co-operative and grateful. Unfortunately all her hostility had become directed on to the Education Authority with which the parents exchanged solicitor's letters about the alleged neglect of Aubrey at school. The moment was unpropitious for change and after what the Authority described as an exchange of 'some degree of acerbity and allegations between the parents and the headmistress', Aubrey returned to the same school.

At 8 years Aubrey was retested on R.S.B. Form M. M.A. 6.10; IQ 85. He still tended to inhibit in difficulty and had not begun to read.

Aubrey's condition remained good, he was growing well, putting on weight and was generally cheerful, friendly and quite communicative. His bowel condition was causing much less anxiety. His educational progress was poor and transfer to an E.S.N. school was still a possibility. He was mixing better, holding his own and not being too aggressive.

Three years later he was continuing on his slow way, still troubled by diarrhoea when matters did not go smoothly, but no blood in his stools. His social relationships remained indifferent, but his capacity for harmonious social relationships was at least as good as that of his parents.

Comment

Little is known exactly about the original cause of Aubrey's colitis, because Mrs. B. was always a grudging informant. Possible clues are his difficulty over settling down after the late evening feed, teething trouble, the wretched housing conditions and

Mrs. B.'s separation from her own mother on whom she was particularly dependent. Then there was the strange story of blood which the mother noticed in Aubrey's stools at 5 months but which she revealed as a guilty secret 5 years later. She was a worrier, aggressive-defensive and quick to take umbrage. She was worried when she weaned Aubrey, and she certainly encountered difficulty. His disturbed behaviour between 6 and 9 months was more likely to have been caused by change in feeding practice than by teething. In the middle of this worrying weaning period, the *fistula in ano* developed and Aubrey went into hospital. There was plenty of somatic evidence of disturbance and it is possible that Aubrey had already begun the withdrawal that was such a marked feature of his later behaviour.

During the early toddler period, Aubrey appears to have been in a delicate balance of health and development, and showed signs of over-control and excessive cleanliness.

During the last 2 months of his mother's next pregnancy, Aubrey was 'very low in health', and 4 months after his sister's birth he broke down with blood in his stools. The fact that he revealed no later jealousy of his sister may have been due to inhibition, but he had so much attention that it was the sister who felt deprived.

The original cause of the bowel condition at 5 months is obscure, but the parents reacted extremely anxiously. The pattern became established that Aubrey reacted somatically to emotional setbacks by diarrhoea, sometimes accompanied by ulceration. Mrs. B. was too anxious to support him during these successive shocks, and so Aubrey had little chance of developing normally through the anal phase. His character growth was arrested at a level of over-dependence, inhibition of aggressiveness, obsessional cleanliness and over-goodness.

The family reaction to the disappearance of his spontaneous aggressivity was an overpowering urge to fight his battles for him. Mrs. B. became truculent, critical and resentful; and she even came to talk of Aubrey as being 'tough' and able to stand up for himself at a time when the only child whom he saw was his younger sister.

The toddler phase cannot last for ever, however artificially prolonged, and his breakdown at 4½ may well have been caused by the looming necessity to adjust to the bigger world. When the surgeon suggested operation, the parents embraced the idea eagerly. Operation represented hope, action, breaking the vicious circle; the diseased part would be cut out. There may have been a punitive element in the parents' eagerness, for it would require enormous forbearance not to visit, however guiltily, something of their anxiety on to the innocent head of the cause of their trouble. Certainly abandonment of the operation was a great disappointment and for a while the atmosphere was tense and critical. Aubrey's rapid improvement combined, we may claim, with counselling by the psychiatric social worker and the psychiatrist helped to restore confidence.

Mrs. B.'s new-found trustfulness did not extend far enough to entrust Aubrey to a school, though he was 7 months over entry age. Her axillary abscess was only an incident in a generally improving situation, but its catastrophic effect on Aubrey indicated the extent of his character deformity and regression. But this time, his mother's attitude had changed for the good; to supporting and imparting confidence to Aubrey in hospital. He responded so well that within 2 months he started school.

The surprising incident of Aubrey's black eye and his parents' warfare with the

L.E.A. fit into the pattern of recovery. Aubrey was becoming less inhibited, but was unpractised in controlling his newly experienced aggressive impulses. On those few occasions when his aggressivity 'broke out', it appeared uncontrollable. His headmistress considered requesting his transfer as unmanageable. Incredible! Fortunately good sense prevailed and the system was not held to ransom by a regressed 7-year-old running amok.

Although his parents continued to complicate matters by their displaced and misplaced aggressiveness, and though his sigmoid colon and rectum were seriously impaired, Aubrey continued to thrive. Confidence had been restored.

A 'stop-press bulletin' can be added:

When Aubrey was 12½ the question of operation was raised once more. Aubrey had maintained his progress, but the continued retention of diseased tissue was doing him no good. Parents and medical advisers were completely in agreement and operation was decided upon. The outcome is still in the future.

VISUAL DEFECT

It has been suggested on page 201 that severe visual defect makes little difference to a baby during earliest infancy, before the visual perceptual system has become organized, and that deprivation of one special sense can be compensated for by intensive employment of the remainder. Provided that the mother keeps in constant touch—literally—with her baby, and gives him the maximum amount of tactile, passive motor and proprioceptive experience and talks to him specifically, the child's relationships can be established soundly.

Unfortunately blindness may pass unrecognized in a quiet, contented and undemanding baby, whom the mother leaves lying unattended in cot or pram. Thereby she will unwittingly convert his partial sensory deprivation into a total state, for he will have nothing to gain his attention. Some naturally out-turning babies will surmount even this difficulty and will pick up signals from the environment, by ceaseless manual exploration and by listening. But perhaps the majority will be defeated and will withdraw, lying inertly or showing autistic movements. If nobody rescues them from their isolation, the outlook for development will be hopeless.

Therefore, blind and visually handicapped children need contact and stimulation by every available route of access.

Jeremy N. (47) 4 months. A Blind Baby

Jeremy was the second child of a professional couple who had a daughter 4 years older. They lived in a comfortable flat with a garden. During the second and third months of pregnancy Mrs. N. had a bad attack of virus influenza, the supposed cause of Jeremy's blindness.

Baby born at term, easy labour, 4 hours, birth weight 8 lb. 12 oz. His eyes were 'stuck up with matter'. Bottle feeding was introduced at one week and was difficult. He remained in hospital for 2 weeks longer than his mother, and an ophthalmo-

logist diagnosed bilateral microphthalmos and choroidal colobomata and predicted that he would not see.

At 10 weeks his parents went away for 2 months on a long-planned lecture tour abroad. Jeremy went to the maternal grandmother. At 15 weeks he went to hospital for 10 days with a urinary infection. He was underweight and poorly developed, with small genitalia and undescended testes. He showed no response to stimuli at 16 weeks and moved very little, but his retardation could not be assessed in view of his parents' absence and his hospitalization.

Jeremy's parents returned at 5 months to find that feeding difficulties had persisted, with vomiting and loose stools. Partial weaning on to sieved foods made matters worse and he went back to hospital for 14 days, for an operation for the relief of intussusception. He was given 4-hourly bottle feeds for one month. He slept poorly for some weeks, but by 11 months was sleeping 12 hours at night. He was also completely weaned, took food readily from a spoon, but refused hard food-stuffs in his mouth.

He was retarded all round. At 9 months he smiled when cuddled and on being spoken to by his parents, and discovered how to roll from his back on to his tummy but not the reverse. He could grasp his rattle and smiled when he heard it.

At 11 months he could not sit up, but could roll in both directions and roll across the room. He could not crawl. He could distinguish light from dark and seemed to see roughly where there was a bar with coloured balls. When picked up, his hands would explore his father's face. He was intolerant both of the pot and of dirty nappies.

Re-examined at 11 months, Jeremy lay on his mother's lap and was happily responsive to her touch. When not actually touching her, he withdrew. He could not sit up unsupported, but if his back were held, he balanced his head fairly well. His all round level of development was that of a 6-month-old child.

His mother was not a warm maternal person, and much of the maternal care came from the father. They appeared to have accepted his blindness, but were guilty about leaving him for 2 months early on. They were full of misgivings about caring for a seriously retarded child. The objective of counselling was to get the parents to give Jeremy the maximum amount of stimulation and contact by whatever route appeared open.

His development was reviewed at 13 months by a psychologist with special experience of blind babies. It was thought that his limited perception of light might seriously interfere with his use of other sensory pathways. His slight peripheral vision was not sufficient for orientation by visual means. He showed a 3-month-old level of snuggling response to being nursed.

At 17 months he was still not sitting up, but could wriggle across the room on his back. It seemed likely that he had some rudimentary vision. His response to sound was minimal, occasionally by a momentary stillness. When he encountered an obstacle, he slightly shifted his direction and did not attempt to explore the object. Much of his time was spent passing and repassing his hands across his face and, seemingly, gazing at them—possibly an autistic mannerism, possibly preoccupation with the play of shadow across his visual field. His mother said: 'He can't bear being held or cuddled and cries and whimpers until one puts him down.'

Mrs. N. devotedly tried to make up by thoughtful attention for lack of spon-

taneity. She tried to follow the advice given at 11 months, to stimulate Jeremy bodily, but she was not spontaneous enough, nor was Jeremy able to accept contact. At the 17 months' examination Mrs. N. gained the impression that the outlook was hopeless and her attempt to give him maternal nurture collapsed. They began to campaign for his admission to a Mental Deficiency Hospital.

Further examination at 19 months showed no development beyond his 11 months' level. He was less responsive than previously, and getting less attention from his mother. He was no longer using his hands for exploration but merely for apparently meaningless passes across the face. He practically never uttered a sound.

With great regret he was placed in a Mental Deficiency Hospital; the combination of extreme retardation, blindness and parental despair made the prognosis hopeless.

Comment

Jeremy's case illustrates the importance of early diagnosis in both its social and medical aspects.

At 16 weeks Jeremy had not progressed measurably from his state at birth. He suffered changes of care at 4 weeks, 10 weeks, 15 weeks, 17 weeks and 20 weeks, so that his unresponsiveness might be ascribed, partly at least, to withdrawal following maternal deprivation and changes of care.

Moreover, if a blind baby does not have feeling contact with his mother he will require a remarkably strong out-turning instinctual drive for progress to ensue. Since, at 16 weeks, evidence about instinctual drives is still uncertain, at least there was nothing yet to indicate that recovery could not occur.

Unfortunately for Jeremy it appears that the quality of maternal care he received after these 5 changes was not of that abounding quality necessary to repair the damage. These parents were loving, conscientious and united, but Jeremy was in need of unusual body empathy, physical tenderness, and wholeheartedness. The parents went away at a vital moment, this was due partly to lack of intellectual appreciation of the baby's needs, but mainly to the mother's insufficient sense of bodily unity with her baby. So they fulfilled an important professional engagement, perhaps at the cost of Jeremy's future.

By 11 months the outlook was bad, because in the absence of visual orientation the changes of care had caused chaos in his development. But though he was still in an infantile status, he was still slightly responsive to his mother. It was impossible to exclude congenital mental defect, for which his various somatic defects were supportive evidence. Jeremy's complete developmental stasis and further withdrawal and deterioration supported a diagnosis of autism rather than mental deficiency, in which latter case there would have been some slow development. Unhappily the parents sensed the doctor's doubts and their capacity to provide for the needs of their child declined.

The main lesson to be learnt from this experience is that when parents have a marginal adjustment to a bad situation, loss of hope may render them quite incapable of caring for their child. The greatest possible care must be taken to give no hint until a confident prognosis can be made.

Edward K. (48) Total Blindness in Early Infancy

Edward had both eyes removed in early infancy because of glaucoma. His parents were extremely guilty about this, for Edward had been conceived before his parents' marriage, and his mother had herself had one eye removed during infancy. She was haunted by fear of heredity that was augmented by guilt over the illegitimacy. The father was a querulous, neurotic man; the mother warm-hearted and tender.

She nurtured her blind infant with tender care, but when Edward was 2, according to the administrative practice of that period, he went to a Residential Nursery for Blind Children. During his prolonged absence 2 siblings were born. In due course Edward passed into a Residential Primary School for Blind Children and, in wartime, visits home were few and brief.

Edward eventually broke down at a Residential Grammar School for the Blind. He was brilliant intellectually; R.S.B. (adapted for the blind) IQ 147. He could not work at school, he was hostile, critical, embittered and impossible. He presented a most difficult problem, for he had no roots. He had affection for only one person, a welfare worker at his first nursery, and in adolescence he was remote from her. He had no durable contact with his family, who were working-class folk; intelligent but uneducated. Edward was a stranger to them, hostile and contemptuous of their ways. His mother accepted his attitude as a just reward for her past sin, but this did not help Edward.

Psychotherapy was attempted at a special residential school for maladjusted boys, but he was the only blind boy there and the necessary educational expertise and equipment were lacking. Edward's hostility extended to the whole learning situation and he was a most difficult case to treat.

Comment

Edward had warm basic emotional relationships and sound somatic orientation. His ambivalence developed at the phase of oedipal differentiation of relationships (see also Chapter 12). The case chiefly illustrates possible sequelae of unresolved family tensions when a blind toddler is sent to a residential nursery.

A balance must be struck between collective education in order to apply the best educational skills and the maintenance of family relationships so that the child does not become emotionally maladjusted and a social misfit.

REFRACTION DEFECTS—MYOPIA

The possible harmful effect to child development of serious visual refractive errors is, as we have already noted, generally unrecognized. The limited radius of the short-sighted baby's range of clear visual perception will not matter until he is walking, for the competent mother of a baby in arms will perform her function at close enough range for the infant's perceptions to be normal, so that even serious myopia may pass unrecognized in a baby.

When the child becomes mobile the situation changes. His inability to see things clearly across the room will cause him repeatedly to be confronted with blurred objects that loom suddenly out of the surrounding mist, out of perspective and magnified. Naturally, such children will tend to be clinging

and dependent, or anxious if not actually touching their mothers. In later childhood they may be babyish or emotionally retarded and, according to temperament, compensating, hyperkinetic or withdrawn.

Kate O. (49) 5.3 years.

The question was a projected operation for correction of a bad internal strabismus; Kate was very short-sighted and had no binocular vision. She had worn spectacles for 6 months and for 3 months had had the left lens occluded. The ophthalmic surgeon wondered about the effect of hospitalization.

Her father was a librarian, a remote bookish person who inferred everything by his remark: 'she doesn't do that while I'm about'. Her mother, a diffident soul, was inclined to agree, but she was Kate's only trusted support. Kate had one sister 3 years older, trouble free.

Kate's main behaviour problem was nervousness. She dreaded going to school, and cried even after 2 terms; she was often sick, and locked herself in the w.c. She refused to continue at Sunday School after her sister moved into another class. At school she was 'panic stricken and very tied up inside'. She made a fuss at a children's party because one of the children was unknown to her.

A very sick pregnancy and a threatened miscarriage at 3 months. Labour, quick and easy, birth weight 8 lb. 3 oz. The mother had a breast abscess at 3 weeks; a week later Kate developed one also, treated as an out-patient.

Kate was a 'good, placid baby and slept well', exceptionally clean, but a poor appetite. Average motor development, but social development retarded; her speech was indistinct. She was accident and illness prone. She fell off a table at 18 months, and developed fears of boys, small babies and cats. She also had recurrent attacks of vomiting and high temperature.

She started school at 4.9 years with keen anticipation but was bitterly disappointed by the teacher's lack of sympathy, and her attitude changed to fear.

After measles at 4.3 years, her left eye was noticed to be turning inwards at times. When she went to school this squint became permanent and refraction revealed a serious degree of myopia. Mrs. O. said that Kate 'was clinging, always hanging on to me'. She was exceptionally clean and fastidious and 'has a mania for tidying up'. She was very affectionate, especially towards the family dachshund. She loved dolls and dolls' houses, and collected worms in boxes, but was terrified of flying insects. She never showed temper, but would sulk. She adored her sister but was jealous of the latter's friends.

Examination

R.S.B. Form L. IQ 110. She tried hard but was handicapped by being allowed the use only of her weaker eye. General comprehension and reasoning good; but hand-eye co-ordination and space perception were poor.

She was a demure little object who dutifully and pitifully subjected herself to examination. She stood still and only touched the toys when practically ordered to do so. She busily made up the dolls' bed but then stood close to the doctor, answering questions in a breathy, almost inaudible whisper. She appeared tense and sighed repeatedly, occasionally she sucked two fingers of either hand and sometimes poked

at the sand tray, without being upset by the dirt. Her imaginary three wishes, after much encouragement, were for a horse, a rabbit and a dog.

Kate was a very in-turning, regressed child who was showing a strongly withdrawing and inhibiting behaviour pattern. Her mother had somewhat over-intellectualized her role; her father was remote, and the sibling rivalry was not negligible. First-year insecurity signs were feeding difficulties, a poor appetite, repeated minor infections and over-rigorous toilet control. In her second year her social retardation, especially in speech, had been striking.

The conclusion was that her short-sightedness and lack of binocular vision had left her extremely uncertain in her relationships with other people, in her body management in three-dimensional space, and in movement.

The Operation

Only the gaining of greater body confidence could break such a vicious circle. Mrs. O. was quite terrified at the prospect of Kate's admission to hospital. Great care was therefore taken; Kate was far too 'good' to be difficult but it was essential to prevent the mother's panic communicating to Kate.

The day before admission, Kate was taken by her mother to meet sister and the nurses. The next day her mother put her to bed, stayed with her until it was time to go to sleep, and promised to be there at 10 o'clock next morning. One hour after her arrival Kate was given her pre-operation medication in her mother's presence and was told that her mother would be there when she woke up after the operation. Mrs. O. returned when Kate started coming round, and she stayed until sleep time, promising to return next morning.

That morning Kate was miserable and her mother stayed all day. By the fifth day, however, Kate had made friends with other children and was very responsive to the nurses. She told her mother that she need come only at normal visiting times (one hour daily), and the rest of her stay in hospital went smoothly.

Kate was seen at one, and again at 3 months, after discharge. Her mother was delighted that Kate was altogether more spontaneous, and managing better, especially in her attitude to school. Kate seemed tense still and was evidently not yet out of trouble, because she tended to run too fast for herself and had fallen over; but it was good news that she was attempting to run.

Retesting on the R.S.B. Form L. 4 months after discharge, her IQ was 115. She appeared to a different psychologist to be lacking in confidence and hesitant. Her organization of visual data was still very poor. Four months had elapsed since the operation and her comparatively slight improvement in intelligence test results was perhaps a disappointment in view of the hopes that had been entertained. It was obvious that she needed more time to effect a further adjustment to her new visual situation. One year later she seemed to be in good form. Her mother said 'she is quite a different child', but her school progress was, on the whole, disappointing.

Comment

The two important factors in Kate's case were a certain inadequacy of maternal support, and her visual difficulties: neither, perhaps, much on its own, but powerful in combination. In face of a mounting anxiety as a toddler, Kate's in-turning tem-

perament caused an inhibiting, clinging and retarded pattern of behaviour. Her slow progress after operation showed the degree of her difficulty.

Special measures were taken to prevent trouble during her hospitalization, and everything went off smoothly. One conclusion could be that careful planning was vindicated, that the mother had derived sufficient confidence to impart confidence to Kate. Another conclusion could be that the outcome had proved the precautions to have been unnecessary.

Bernard P. (50) 4.2 years

Bernard was extremely restless and destructive. He climbed on the chimney-piece, smashed the ornaments, swung on the curtains, cut a hole in his mattress, broke a mirror, dug holes in the table, rushed into traffic heedlessly, played with fire, wetted his bed and soiled without restraint.

Bernard was born after a precipitate labour. He failed to suck for 3 days, then developed eczema and after 10 days, asthma. He returned to hospital for 3 weeks, where his hands were tied to stop scratching. His mother fed him. Bottle feeding was introduced at 3 months but it often took him 2 hours to take 2 oz. of milk.

At 2½ years he was 3 weeks in an isolation hospital with eczema and measles; his parents were not allowed to visit. His hands were tied. He went very thin and did not recognize his mother on discharge. Then he went to a day nursery, but was excluded after 6 months because of destructiveness.

His mother said: 'He is not afraid of anyone, very daring, he jumped off the breakwater into the sea during our last holiday.' He was insatiably curious and asked endless questions. He was affectionate with his sister of 5½ and brother of 2½ and, on occasion, helpful at home.

Both his parents had had an orphanage upbringing, Mrs. P.'s recollections being particularly bleak. Mr. P. was abroad with the army from 11 months until Bernard was two.

Examination

Merrill Palmer Scale C.A. 4.2; M.A. 3.11; P.R. 40+. He had a strong pressure of activity and he inhibited motor activity barely long enough to get the instructions.

Bernard looked quite cherubic, with a charming smile; he did not mind leaving his parents, and showed no realization of the occasion. He was clumsy on the stairs. His play was extremely active, formless and distractable, with chance associations. Toys excited him. He asked countless questions, which could have no sensible answer or which he could have answered for himself, e.g. 'What is plasticine?', when holding a piece, and 'Is this a tin?', 'Where is the sink?', etc.

He put a ball in the empty sand tray, saying 'playing football they are'. He filled a dolls' w.c. with sand, put a toy cow with its head in the pan and said 'He's going to be rude, he's eating the toilet'. He spilt sand on a chair, fetched a toy dustpan and brush, but was so clumsy that with good intentions he swept the sand on to the floor. He was very short-sighted.

Comment

What was the effect of serious short-sightedness in Bernard's case? The clinical picture was that of first-year insecurity in an active out-going temperament. Both

parents, with their orphanage upbringing, appear to have lacked tenderness, and the father was absent during the toddler period. Infantile eczema interrupted Bernard's relationship development and he compensated by active, out-going, seeking behaviour that to some extent achieved its object.

During the second year, the age of mobile exploration, Bernard's myopia let him down; he was incompetent in the perception and management of object inter-relationships and movement, and defective in concept formation. His insecurity was not enough to inhibit him, so that his overactivity made a dangerous combination with his defective orientation. He was fearless because he did not perceive danger. His world, beyond a narrow range of myopic vision, remained chaotic, unorganized and therefore not understood.

His destructiveness was not that of interpersonal hostility, he was a friendly, loving child; but destructiveness is bound to provoke retaliation by other children. The day nursery excluded him after 6 months and the infants' school might well be even less tolerant. The therapeutic problem was to correct his vision and to introduce him to a wider world of relationships. Unfortunately, the family left the district a few weeks after the examination.

HYPERMETROPIA

The long-sighted baby is in a converse situation. His field of clear vision lies beyond arms' length, so that the hypermetropic, like the blind, child is at the mercy of his mother's handling. He will be dependent on bodily contact for formation of his intimate relationships and if this fails he will have no foundation on which to construct wider visual percepts. The attendant risk of hypermetropia is, therefore, that of lack of orientation.

Philip K. (51) 4.2 years

Philip's backwardness of development was patchy. He was left handed and his odd gait had been thought to be due to a mild pyramidal lesion, but it disappeared when his hypermetropia was corrected by glasses at $3\frac{1}{2}$ years. Gesell Developmental Scale: Motor, 2 years; Adaptive, 18 months; Language, 15 months; Personal Social, 3 years.

Home circumstances were good, father was a commercial traveller and the parents were a united couple. There was a sister $4\frac{1}{2}$ and a brother 3 years older.

Labour was prolonged over 10 days; birth weight 7 lb. 1 oz. Early infancy was uneventful; breast fed for 5 months, weaning easy, but retained the bedtime bottle until 12 months. He sat up at 11 months, with poor balance, and then pulled himself to his feet, holding on. He passed suddenly into a phase of screaming attacks, 'he cried night and day' (attributed to teething). His development halted, he lost the ability to stand or to balance himself and a convergent squint appeared.

He resisted toilet training from 5 months and even at 6 years was not highly reliable. He said single words at one year, but nothing more until nearly 5 years old. His mother taught him to walk by unremitting effort between $2\frac{1}{2}$ and $3\frac{1}{2}$ years. Sleep had been disturbed until the last 6 months. He had fed himself successfully since his acquisition of glasses.

Philip was very affectionate, happy with his siblings but willing to play on his

own for hours. His skills were those of less than 3 years old—he recognized the family car, knew his own street, could use his hands skilfully enough to put blocks correctly into the sorting box. He normally indicated his wants by leading the adult by the hand.

He had a number of specific fears, e.g. of strange places, small rooms, cats and dogs, but not birds. When distressed he would smack his own face.

Examination

Philip was admitted to hospital for observation, and although visited daily by his parents, was utterly forlorn. He sat listlessly and cried if approached, like a deprived 2-year-old. He allowed himself to be picked up, stopped crying and passively accepted attention, but cried bitterly on being put back in his cot. He was discharged and when seen again as an out-patient he accepted separation from his mother. He was small, pale-faced and wore thick convex spectacles. On an incomplete assessment on the Griffiths Developmental Scale he nowhere exceeded a level of 2 years. Hearing and speech development were at less than 15 months, hand-eye co-ordination tasks, 22 months. The test suggested, inconclusively, very subnormal intelligence.

In the play-room Philip had the appearance of great concentration. He took a toy car and some lead animals, and crawled around the room on hands and knees making conventional traffic noises. He said a number of incomprehensible words, and once seemed to enunciate 'car'. He perseverated indefinitely in play. When addressed by name he looked at the doctor and occasionally gave him a toy to hold. At his mother's request he handed the doctor a matchbox.

His mother emphasized that Philip had 'a tidy mind', must have everything orderly and secure, his clothes folded neatly at bedtime and all doors closed.

At 5 years, 'satisfactory progress' was reported according to Gesell norms: Motor 2 years; Adaptive 2 years, with some scatter; Language 23 months; and Personal Social over 3 years. He was not yet reliable in toilet habits, but speech was his most satisfactory development. He was still showing fears and was very excitable.

Comment

The differential diagnosis lay between mental deficiency and serious emotionally determined retardation. Suggesting the former were dysplastic body build, small (but not microcephalic) head, and generalized motor clumsiness. Suggesting the latter were: the wide discrepancy between various sectors of his development, his rapid learning since wearing spectacles, and behaviour resembling that of a poorly orientated child, defective in body concept and in space appreciation.

Given his inferior intelligence, what was the effect of his hypermetropia? Before he wore spectacles he could have seen nothing clearly within about 6 feet, so that he was secure only in familiar social situations. His toddler difficulty in orientating his body to movement was revealed in his serious motor and adaptive retardation, but in personal-social aspects he was not so retarded. He was lost in hospital, away from his familiar surroundings.

His 4-year-old play was that of a poorly orientated toddler and his perseveration was due to imperfectly organized experience. He was afraid of dogs and cats, which came near, but liked watching birds, which remained in his field of clear

vision. His obsessional rigidity represented an attempt to organize his experience.

Therefore, his unevenly retarded emotional development was due to a combination of inferior intelligence with poor somatic orientation due to his visual handicap. The educational prognosis was poor.

Joe L. (52) 8.5 years

Joe lived in a 2-roomed flat with his parents and 6-year-old brother with whom he shared a bed, in a house occupied by 3 families; 6 adults and 14 children. The presenting problems were bedwetting, which had started 9 months previously, backwardness at school and persistent truancy.

The family atmosphere was bleak and pinched. Both parents had come from a Scottish mining area. Mr. L. had been discharged from the regular Navy during the war, with peptic ulcers, and his occupations had since varied from mortuary attendant to unskilled engineer. Mrs. L.'s main interests seemed to lie outside her family. She said she was very 'nervy' after Joe's birth. The children had both attended a day nursery as toddlers, and had always been out during the day. Mrs. L. had worked for the previous 2½ years; Mr. L. usually gave the children their tea and put them to bed.

Mrs. L. was not a reliable informant but there was no evidence of difficulty during Joe's first year. Bottle feeding had been easy, but Joe was always hungry, unlike John, who was quiet and satisfied. Weaning was easy. She claimed that he walked and talked at 11 months and that toilet training was easy, though he had occasional 'accidents'. Bedwetting had started when Mr. L. changed from shift work to being at home every evening. Joe had 'always been a bad sleeper and has always sucked his thumb'.

Mr. L. worried about Joe's scholastic retardation and fussed because he had no homework to do. Joe's truancy had been unknown to the parents until the Attendance Officer called.

Mrs. L. said that Joe had always been girlish, loved dressing dolls, and girls' toys, and she immediately associated this with his many questions about sex. He had spoiled a toy cowboy gun set. She herself, had been a tom-boy, but had wanted girls of her own. John was quite different and very tough, but the two were firm allies.

Though a bully, Joe hated fighting and cried when in minor trouble. He often talked babyishly, and sometimes fantastically about an imaginary giant who would prevent him doing things. He liked swimming. He often would spend his sweet money on presents for his parents—to their embarrassment, and on bulbs and seeds.

The lack of close relationship between Mrs. L. and her family was striking. The children were much left to themselves and John had to fight Joe's battles for him.

Examination

R.S.B. Form L. IQ 97. Scholastic attainments negligible; he was markedly left eyed, even doing his designs from right to left. He had little stomach for tasks beyond his immediate comprehension.

He had worn spectacles for the last 6 months. Both eyes hypermetropic and astigmatic, worse in the left eye. Uncorrected vision 36/36. His parents had never noticed his poor vision.

He was short and thin, but healthy looking; poorly dressed but not dirty. A

school medical officer had reported once, 'his clothes were in a shocking state, almost stiff with dirt underneath'. In the play-room, he was busy. With extreme care he painted straight on to the paper, in primary colours, a picture of a ship at night. He talked at random, unceasingly, exercising no censorship of remarks. He was highly uncertain of himself and communicated a sense of urgency in everything he did. He talked about the giant quite seriously, as a supernatural, protective, fantasy father figure; kindly but critical; competitive and apt to punish one if one did not watch out.

Mrs. L.'s appearance contrasted with Joe's scruffiness. She evidently had an indifferent relationship with Joe, did not understand him and was impatient. She was unreasonable in complaining that the family with 9 children who occupied the ground floor would not allow her children to pass through their living-room to the garden. She was also content that her children came back to an empty flat after school. A neighbour kept an eye on them until Mr. L. got in half an hour later. She herself returned 1½ hours later.

Comment

Joe was suffering from a generalized second-year disturbance (see Chapter 11), complicated by his visual handicap. His mother was a smart, perhaps narcissistic and unmaternal person, who had married a pedestrian man 15 years older, maybe through emotional immaturity and father fixation. Joe's marked out-turning temperament enabled him to get over lack of maternal support during the first year without showing more than greediness. Hypermetropia handicapped his second-year orientation and he was babyish and unconfident. His fantasy of a protective but critical giant may reflect the remoteness of his perceptions. His obsessional attempts to organize the environment contrasted curiously with his hyperkinetic extraversion.

Mrs. L.'s partial repudiation and Mr. L.'s partial assumption of the feminine role confused the issue and provoked feminine interests and oedipal guilt in Joe. Other complications were: maternal neglect which resulted in this obsessional and rather feminine boy being dirty; and his brother's greater robustness.

Bedwetting probably resulted from the heightened tension of father taking over evening care, together with transfer to the less protective junior school.

When his vision was at last corrected Joe set about the obsessional organization of his environment in the face of a defeatist attitude to learning and school achievement. Treatment was badly needed, but taking Joe to hospital did not fit into Mrs. L.'s working day.

DEAFNESS

DEAFNESS

The problems of deafness will be dealt with in the current work only by illustrating with clinical examples how hearing defects can become an issue in the Child Guidance world.

As already discussed (page 202) serious deafness is not often a bar to the formation of infantile relationships. A deaf child is, of course, in a vulnerable

position, being more dependent than a hearing child upon the quality of the parental nurture.

After the age of 2, speech acquires an ever-increasing subtlety and importance in communication, and a deaf child will be at a correspondingly greater disadvantage. Like the partially blind, the partially deaf child may be worse off than the totally. With the latter the parents may entirely reorient family life so as to help their child learn to communicate by lip reading.

The child whose aural responsiveness varies may provoke a different parental reaction. Commonly they will shout at him in pidgin English, and so destroy the child's chances of learning lip reading because of the distortion of lip movements. Moreover, subtlety of mood, attitude and feeling cannot be communicated by shouting pidgin.

Being bawled at in basic English, and with no abstract concepts in oral communication, tend to keep the child's relationship system at an infantile level. The child's unwavering stare as he attempts to understand may antagonize the parent, especially one with a sense of guilt about deafness. Parents will say 'he can understand perfectly well when he wants to' and this suspicion may breed a critical attitude. It may be true that a child will understand more readily when secure and familiar with the situation; and at other times not *want* to understand. The suspicion that may lurk in the adult's mind that the deafness is partly wilful may contribute in part to the unpopularity also of the deaf adult.

Gordon R. (53) 13.5 years

Gordon was referred for extreme retardation at school and in speech. He attended a Special School for the Deaf, which specialized in the education of the totally deaf.

The family, consisting of parents and two boys aged 13.5 and 7 respectively, lived in a small suburban house with garden, and the boys shared a bedroom. It seemed that both parents were anxious and guilty about Gordon's deafness and his brother's severe asthma.

Both were inclined to project blame and to be critical of the other for their attitude, and the mother resented that the father could escape more often from the responsibility. She felt that the brothers bickered unceasingly and she took a highly emotional and sometimes despairing view of family relationships.

Mrs. R. had a miscarriage 2 months after marriage, and Gordon was born 5 years later. Pregnancy and birth were normal, but the mother's milk failed and Gordon cried so much that he was taken to a children's hospital at 3 months.

The hospital diagnosed craniotabes and treated him with ultra-violet ray. There were no other signs of rickets. At 2.11 years, congenital nerve deafness was diagnosed. Early motor landmarks were late but not outside the normal range. He walked at 18 months and began to say words after 2 years.

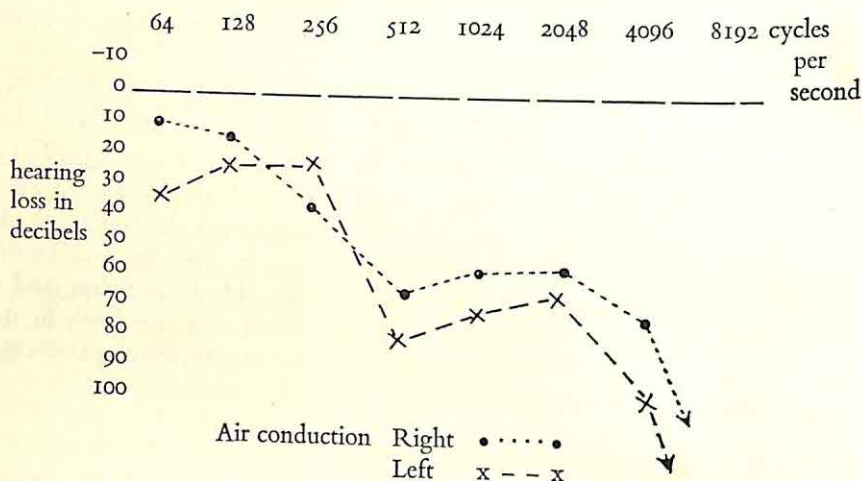
At 4½ he was sent to a special day school for the deaf where he was babyish and clinging, and conformed little to school life. At 6.4 years his report stated that he could 'lip read well those words and phrases he has been taught to say properly'. He was better at play and handwork but made no attempt to read or recognize figures.

'Gordon has improved beyond all expectation and now takes his place in class without fuss. He seems perfectly happy both in the classroom and the playground. He has a great sense of fun and gets on very well with everyone.'

At 10 years he was evacuated with his mother and brother for 6 months. He enjoyed his ordinary school, but Mrs. R. remarked 'I often wondered what he can have done there'.

At 13 years Gordon was affectionate, dependent and shy, nervous of strangers and easily upset by changes. He was fond of drawing. 'If you speak to him harshly he seems to all go.'

Audiometry at 12.10 years:



At 13.5 years:

Seguin form board. M.A. 12 years. Ferguson form board. M.A. 11-12 years. Healy Picture Completion I. M.A. 7-8 years. Healy Picture Completion II. M.A. 8 years. Kohs' Block Design. 17.6 years. Reading. Average for 6.3 years.

The wide scatter of results was due in part to anxiety and in part to incomplete understanding of the problem.

At examination he was small and tense, but friendly and anxious to please. His hearing difficulty was increased by a certain withdrawal of attention from conversation. His lip reading would carry him through only a conventional situation, but with anything unexpected he would speak hopefully and inaccurately. As well as a severe halting speech defect he had difficulty in expressing ideas. He completed with pleasure a picture of a wintry scene in primary colours, rather a juvenile effort for his age.

His speech difficulty was a combination of hearing and emotional difficulty. He made mistakes due to misplaced sounds, but was inhibited also by poverty of vocabulary. He used a kind of pidgin English, e.g., *Question*: 'How do you fry eggs?' *Gordon*: 'Well you take that stuff—not butter—the white stuff, and you put it in the plate with the . . . (mime for handle) . . . and put it on the gas.' He wore his hearing aid very little.

Re-examination at 14.3 years confirmed the severe high tone deafness, but his hearing aid should have made face to face conversation possible.

After 3 months' remedial education his reading age had advanced from 6.2 years to 7.1, which advance had been accompanied by a considerable gain in confidence. His school reported: 'He has shown an immense improvement in mixing with other boys. He has really come out of his shell and can hold his own.'

At 14.4 Wechsler Bellvue Scale Verbal IQ 60; Performance IQ 98 (or 108 if prorated for tests in which he was handicapped). Repeated at 15.3 years, Performance IQ 105; and at 18.1 years, 106.

Eventually Gordon started training in skilled leather work and so became able to earn his living, though his educational level was low.

Comment

This account of Gordon does not do justice to all the work done with this family over 5 years. Remedial education was the focus, but in addition much support was given to his mother. To reconstruct the past: the early infancy hospitalization apparently had left no mark, but after his deafness was recognized he regressed to such a degree that he was sent to a special school for the deaf. A regressed child still in a stage of primitive body relationship formation and communicating in pidgin English could not adjust to the limited degree of abstraction of relationships existing at school. He clung to his mother but, with good basic relationships, he adjusted in time. But he had neither the heart nor the will to tackle lip reading seriously, nor the special discipline of attention needed for success. Eventually a compromise solution was adopted, he was found an occupation in which his handicap would be minimal.

Thus, because the whole family could not adjust, he was handicapped by his partial high-tone deafness more than even a totally deaf child need have been.

LOSS OF HEARING

Eric G. (54) 6 years

Eric was one of the, happily now disappeared, cases of deafness that resulted from the early streptomycin treatment of tuberculous meningitis.

Eric was the only child of Jewish parents; his father was a factory worker. Eric was born after 6 years of marriage, following a miscarriage the previous year. Mrs. G. faithfully followed medical instructions, her milk supply failed to her disappointment, but otherwise early infancy and family attitudes were healthy. Quite exhaustive historical investigation revealed no early problems, notwithstanding a charge of maladjustment made later by an uncomprehending headmistress. The only idiosyncrasy ever discovered was that he was unusually particular about cleanliness and actively co-operated in pot training. His mother said: 'even if he were sick unexpectedly he would try to hold it in his hands rather than mess the bed.'

His mother was certainly very bound up in him during infancy, she had given him all her attention, and he was affectionate and responsive. She wished to assuage the memories of her own childhood, as the oldest of a long family in a slum. 'My father was none too good with my mother.' She was sensitive about rough behaviour, but Eric was gentle and amenable, though 'bubbling over with high spirits'.

He was not at all keen about going to school at first, but eventually settled down. At school he was 'a studious little fellow'; not very successful with other children, and often out to impress the adults to whom he would give 'a comic turn on his own'.

Three days before his sixth birthday, Eric was admitted to hospital after a fortnight's illness. He was semi-conscious and was having right-sided convulsions. Tubercle bacilli were found in the cerebrospinal fluid, and a healing primary complex in the chest.

Immediate treatment was given with streptomycin, intrathecally and intramuscularly, and a frontal craniotomy was made on the following day. His condition remained poor, with low C.S.F. sugar, and he was given tuberculin intrathecally for 3 months. Thereafter he improved, gained weight and became alert and happy. Intrathecal treatment was discontinued after 18 weeks.

His deafness was first noticed about one month later and he had occasional nocturnal enuresis and faecal incontinence. His conversation appeared incongruous and often silly. The hospital thought his mother had been over-protective and ascribed his trying behaviour to prolonged separation and increasing isolation.

Ten months after admission he continued to improve, and intramuscular streptomycin was discontinued, his C.S.F. being almost clear. The residual left-sided hemiparesis was improving, but his deafness was worse, though a little relieved by a hearing aid. The enuresis was better, but his behaviour had deteriorated sadly. He was very destructive with toys and sometimes played with his faeces which he had been known to hide in his locker. He was a nuisance in the hospital school and refused physiotherapy exercises. He had little interest in things, though he was beginning to lip read. He was anxious to have attention. His talk was inconsequential 'and his expression and gestures at times appear quite fatuous'.

At his first psychiatric examination he had a confiding manner, but his gait was clumsy and his speech slurred. He negotiated stairs with difficulty, but independently, and talked without cessation in a loud, unmodulated voice.

His neurological disabilities were: some residual left upper motor neurone leg weakness; left upper motor neurone 7th nerve weakness; left internal squint; a basal ganglion motor speech defect; midbrain facial immobility; lability of emotional expression; and a hint of echopraxia, irradiation of motor impulses and unusual susceptibility to rhythm.

His excitement was almost manic, he was very quick on the uptake, noticing trivialities and very distractable. He was quick with lip reading. Left to himself, his movements became more orderly. He started a game of skittles, but suddenly was excited by seeing a tricycle. He asked if he could ride it, but completed the game before riding the tricycle clumsily. He did not leave activities unfinished.

His social relationships were quite unreal. He used adults as playthings, was promiscuous with affection and wanted to have kisses all round. There was much display and miming, which adults regarded as comic, but which appeared to be serious to him.

Fistula in ano delayed the desired discharge from hospital. Seen one month later in hospital, his unreality, fatuity and babyish behaviour had increased, while his neurological signs, other than the bilateral nerve deafness, had decreased. Discharge from hospital was of paramount urgency.

His mother visited him for several hours daily in order to 'get used to him', as the hospital put it; and he became less restless. Wetting and soiling ceased. He went home 3 weeks later, and his mother was advised to devote herself exclusively to him for 3 months and not send him to school.

Two months later, Eric was looking very well. He was cheerful, friendly and moderate in his demonstrations of affection. He examined the toys vivaciously and commented on them in a loud sing-song voice. His vocabulary had increased and his speech was more intelligible. Both he and his mother seemed to have a sounder grasp of reality. Unfortunately in her eagerness Mrs. G. had taken the advice of a speech therapist to try him out in a normal junior school. The headmaster, was alerted to the situation, and Eric attended for one week and then took a violent dislike to his teacher and refused to go.

Educational difficulties then began. The only convenient special day school for the deaf was intended for congenitally deaf children, and was not adaptable to special needs. There was no alternative and Eric started there 6 months after his discharge from hospital.

At the end of the second term the headmistress made a special report: 'This child's behaviour has been so bad lately that I asked the school medical officer to call and discuss the case. He is very aggressive, bites, kicks, demands adult attention and sulks. Other parents are complaining.'

'The child has already been seen by (the child psychiatrist) as he was found to be maladjusted after his recovery from T.B. meningitis at 6 years.'

'The S.M.O. and I are agreed that it would be wise for him to be seen again by the psychiatrist—especially as I think the mother needs direction. She has threatened the child with prison if he bites again.'

'Could this case be treated as urgent, please?

'P.S. I myself do not consider that the child is rightly placed, he should not be with congenital deaf children.'

When re-examined at 8.2 years, Eric co-operated well. W.I.S.C. Performance IQ at least average, though he failed to understand some instructions. His retention of language was quite remarkable; the psychologist described him as a 'determined verbalizer'. Word Recognition Age 6-7 years; lip reading was beginning. He was very dependent on approval and upset by failure.

Clinically, his hypomanic distractibility had increased, but his memory was retentive and his attachments to people, strong. His lip reading was handicapped by fleeting attention. His mother appeared greatly troubled with the family's social and educational perplexities.

At 8.6 years Eric was transferred to a day school for the partially deaf. Seen 4 months later, he was, as always, willing and friendly but restless and difficult to keep occupied. His aggressive feelings were expressed in clowning. On the whole he had settled well to the new school. His speech was, perhaps, less clear and his vocabulary decreasing but he was paying more attention to lip reading. His communicatory gestures remained excessive.

At 10.6 he completed the W.I.S.C. Performance Scale, except for the coding item which he ignored. Performance IQ 97. Schonell Graded Word Test Reading Age, 8.6. His speech was rapid and monotonous and difficult to understand. His descriptions were comprehensible if a considerable kinæsthetic element was in-

cluded. He had an almost uncontrollable need for physical contact of a pregenital type. He was moderately well placed in school, where his behaviour was not a subject for complaint.

Comment

There was no convincing evidence of difficulty existing before Eric's illness. His rather elderly mother had 'only son anxiety' and he took poorly to infants' school. His was an out-turning temperament. When he went into hospital, comatose, he was unconscious for a further month. His mother experienced having her only, and much loved little boy taken away, dying, as she thought; she could do nothing to help; Eric did not even know she was there at his bedside. When the miracle saved his life she still had to watch helplessly while he lost his hearing and while his behaviour became strange and frightening.

How did life appear to Eric as he regained consciousness in that hospital ward? He had lost contact with his mother; friendly but impersonal strangers were treating him like a baby, and, being compliant, he responded without trouble, at first. However, returning health and his active, out-turning temperament led him to attempt to bridge the gap of emotional remoteness surrounding him. In his regressed state this meant exaggerated smiles, pantomime gestures, kisses all round and hunger for physical contact. Only his mother could satisfy his physical need and she was inhibited by her awe of the hospital. She thought that mothers should not cuddle their 6-year-old sons in hospital like toddlers in the privacy of home; that the nurses would say that she was a fussy, over-indulgent mother and 'spoiling him'. She was too inhibited to do more than give him a surreptitious kiss.

The situation was paradoxical. Though the nurses were treating him at the level of a toddler, his mother from whom he desperately needed such treatment, was not.

At first his increasing deafness made little difference; hospital routine could be followed by visual imitation, the nurses need say little to him and his mother visited for only 3 hours per week. Later, with increasing deafness, he received the inevitable treatment. They shouted at him in pidgin English, accompanying their shouts with exaggerated mime. This, then, was the way to behave. Eric responded in kind and overdid matters. The adults were amused and encouraged the cute little fellow who had recovered so marvellously and who, so sadly, had gone deaf. But after a few months, Eric's frustrations and lack of emotional satisfactions led to more seriously aggressive—regressive behaviour. He soiled and wetted, destroyed toys, was uncooperative and eternally fatuous. The doctor in charge wrote: 'I am feeling rather lost.'

The first need was to rehabilitate the mother; to help her to understand Eric's predicament more clearly, and to give practical help with lip reading. Most important was to make her feel useful, to realize that only she could perform the essential services for her son. It was difficult for her to judge the level at which to treat him. She vacillated between responding too much to his infantile needs and anxiously over-pressing him.

The main handicaps on Eric's side were: the late effects of his massive regression; the lack of subtlety in the remaining media of communication, by which mainly concrete concepts were conveyed; and the hangover of his practice of miming extravagantly. In spite of these handicaps, Eric's curve of readjustment was not unsatisfactory.

Dennis K. (55) 13.2 years

Dennis was examined on an urgent report from the medical officer of his residential school for the deaf: 'This boy is physically fit. He suffers from nocturnal enuresis; he has a psychopathic personality and there have been behaviour problems. I would recommend his admission to hospital for psychiatric assessment.'

A detailed report from the headmaster included the following summary: 'He is in a very disturbed state, e.g. he started a fire in the school sanatorium and destroyed 24 sets of P.T. equipment; he has stolen two bicycles, but as they were both returned, the police have taken no action; he masturbates frequently and in public to the embarrassment of pupils and staff. The school is a mixed one, and although the pupils are deaf, they are not blind. He steals and is enuretic. He appears wrapped in a dream world and is unpopular with other children.'

'The school is at present decorated with paper for Christmas and this, coupled with the fact that a box of matches was discovered under Dennis's pillow has caused the boy to be tailed constantly by one member of the staff.'

Dennis was the youngest of 3 siblings, the next older being also deaf. His deafness started at 2½ and was total by 4 years. At home he was ill-fed, ill-clad and handled neglectfully. From 4½ to 6½ he was in a residential home and attended a special school for the deaf, daily. At 6½ he returned to his parents and attended a different special day school. At 8½ he and his sister went to a big residential special school. Because of enuresis he was transferred, at 9, to a small residential junior school for the deaf where he seems to have had his only even moderately happy time, and formed a good relationship with the Head.

At 11 he was transferred on grounds of age to a senior school, where he was aggressive and disobedient, seemed 'lost and sucked his thumb'. He was sometimes the only child left at school during the holidays.

After 16 months he was sent home to attend the same day school, but 3 months later two women independently complained to the police about Dennis assaulting them. Dennis was well known locally for his 'affectionate behaviour', and his kissing in the street of female acquaintances was accepted as his idiosyncrasy. The two women concerned were strangers. The police, knowing this, merely recommended his removal from home again, and Dennis was sent once more to the big residential school in which he had been unhappy at the age of 8½. After 6 months, his admission to mental hospital was requested.

According to repeated tests, Dennis was of average intelligence. He did not speak and his capacity to lip read was patchy, but he used a mixture of sign language, lip reading and mime. When not lost, he was affable and co-operative. His reading was practically non-existent and his grasp of verbal idiom poor. He was not responding to an exclusively oral method of teaching.

Psychiatric examination through a deaf interpreter whom Dennis knew was scarcely a subtle procedure. Except for his deaf muteness his behaviour was normal and friendly. At 13.2 years he was a tall adolescent, certainly too grown up to kiss strange young women in the street. He was attentive and courteous, but relapsed into remoteness from which he could easily be aroused, when his attention was not engaged.

Comment

The disturbance of Dennis's behaviour was not other than might be expected in a severely handicapped, emotionally neglected and frustrated adolescent, who had been in a state of non-communication in a repeatedly changing and impersonal environment.

Dennis's home conditions were so unsuitable that at 4½ the welfare authority sent him away for 2 years; and repeated this after Dennis had returned home for 2 years. Two further changes of boarding school cut him off from his home for two periods of about 2 and 4 years respectively. It seems likely that the capacity of his parents to manage broke down under the impact of two deaf children.

From 9 to 11 Dennis lived quietly in the very protected circumstances of a small, special school. But his difficulties of communication had kept his conduct of his human relationships at a babyish level of simple gesture and physical demonstration. He was completely denied any experience of more abstract human contact and of adaptation to the rapid give and take of social intercourse.

To the uncomprehending Dennis's conduct appeared delinquent, even psychotic. He was likely to continue to suffer great injustice from well-meaning people.

Postscript

Two years later the last sentence read as an ironic prophecy. Two further failures at residential special schools for the deaf, had brought Dennis's total of failures at special schools to 3 day and 6 residential. After 3 months at home he was bored, unoccupied, unsupervised; and he had a little orgy of driving lorries away without their owners' consent.

The magistrate, incredible though this may seem, committed this unfortunate youth to an Approved School; though how an Approved School could succeed when special skilled handling had failed, was impossible to foresee.

After a few weeks, Dennis was sent home, where he remained for a further 6 months, bored and idle. His father had a serious accident, which badly disturbed Dennis and he recommenced driving lorries away. After several escapades he crashed a lorry 50 miles from home, and the police, reluctantly, charged him.

At the magistrates' Court, after a remand of 6 weeks in prison, the prosecution argued that Dennis be committed to the State Institution for Criminal Mental Defectives; making use of an anomalous clause of the Mental Deficiency Act (now to be superseded by the Mental Health Act 1959) which defined a class of 'moral deficiency'.

Fortunately the Court, aware of Dennis's background, decided to make yet another attempt to help him, though it is to be feared that the available facilities are now no better than when Dennis was first in trouble. The case illustrates tragically the extreme potential vulnerability of the deaf-mute child.

Chapter II

General Second-Year Problems

IN addition to the gross orientation failures and the psychosomatic disorders that have been illustrated by case descriptions in Part IV, there are some more generalized difficulties to be considered. The common theme of these, reduced to simplest form, is a disorder of the control of aggressiveness. In Chapter 8 we have discussed the genesis at the time of weaning, of disorders of aggressiveness or as we have preferred to term it—aggressivity. It is our task now to trace further the general effects of these.

The various factors to be considered include: basic temperamental pattern—out-turning and in-turning; the nature and degree of the disorder of aggressivity; and the effect of the controlling or compensating reactions developed both by the child himself and the adults around him.

OUT-TURNING REACTION

Tommy T. (56) 6.3 years

Tommy had been admitted to hospital for full investigation of his soiling and while there was quite clean and dry. No physical abnormality was found and he was referred to the Child Guidance Clinic.

Mrs. T. complained more of general behaviour difficulties than of soiling. Tommy was getting progressively naughtier, cheekier, and crying and whining increasingly. The mother worried most either that he was naughty and cheeky; or crying, whining and clinging, according to her mood of the moment. Poor appetite had been another recent development.

The soiling had started about 6 months before referral, and Mrs. T. thought that he did not know when he did it, since he always protested he did not know when he was dirty. She worried about the continuous washing and buying of new clothes. When going out, he often soiled himself again while his mother was dressing herself. For some time she did not inform the father, as she was afraid of his punishing Tommy too severely. She tried smacking, Tommy seemed ashamed but could not help it. Father eventually said that he would not be given any more presents until he was clean. He did not become clean, but father kept his word for 6 months. Previously Mrs. T. had felt that the father was over-indulgent and had spoilt Tommy by giving in to him. She herself believed in strictness.

Since the soiling began, Tommy had started to tell lies, cry and whine, and was cheeky and naughty with his family and the neighbours. About a year ago the family had moved to a country housing estate, to a 5-roomed house with garden, and Tommy had promptly gone off his food. He disliked bread and butter, milk and

green vegetables. He would give away his sweets. He liked chips best, and though she thought them bad for him, his mother let him have them.

Mr. T. was a taxi driver, aged 36, reported to be a very good father and fond of the children. He drove his taxi in London throughout the war. Mrs. T. described him as an indulgent and kind man, who, however, would stick to his principles.

Mrs. T. thought of herself as timid, quiet, sweet by nature, and somewhat dependent. She was distressed by aggressive, difficult and dirty behaviour, and particularly by Tommy's filthiness. Apparently she approached life with preconceived ideas of what ought to happen, rather than with spontaneity. The older child, Jean, aged 13, had been a source of great worry because of chronic rheumatism.

Tommy was a wanted child. Pregnancy and confinement were normal; birth weight 8½ lb. The mother lost her milk after one week, as she had also done with Jean. He gained well on Ostermilk. He was a happy, contented baby and his early childhood period would have been pleasant for his mother, had not Jean, then aged 7, contracted rheumatic fever. Neither she nor Tommy had been worried by the flying bombs.

Mrs. T. brought Tommy up by the book, with great care. She followed a strict routine to the letter. Her rather progressive baby book advised Farex at 3 months; other solids and a cup at 5 months. He refused the bottle thereafter. From then he went on to rusks, sieved food, etc., and there were no difficulties during the first year. He walked at 11 months, and said a few words like 'toys' and 'boat' distinctly.

He was a few days in hospital with pneumonia at 6 months, but no after effects were noticed. At 14 months he had a serious attack of bronchial pneumonia, was unconscious at home for 6-7 days; meningitis was suspected and he went into hospital for 2 weeks. At 2 years he was in the same hospital with bronchial pneumonia for another 2 weeks. On both occasions he seemed happy in hospital and on discharge.

Toilet training was a major issue. The lying-in hospital advised starting at once in order 'to get the child thoroughly trained'. Mrs. T. felt very strongly about dirtiness, so she sat Tommy on the pot before and after every feed and when she got him up, until he obliged.

At 6 months he grunted for the pot. He was perfectly clean and dry at 1 year by day, and dry at night at 18 months. So that though Mrs. T. was very proud of her training, she did not gain much on a less persevering neighbour.

Mrs. T.'s description of Tommy was so illuminating that it is worth giving almost in full: 'He is very different from his sister who is quiet and never gives us any trouble. He is cheeky and is always quarrelling with Jean—kicking and smacking her if he cannot get his own way. He's a bit jealous of Jean, always saying "it isn't fair". He roams about a lot by himself and comes home filthy dirty. He says he is "tough" and gets angry if I tell him off about getting his clothes dirty and says "you want to make me look like a girl". I have to be careful because he has had bronchial pneumonia and gets annoyed when he has to have a hot bath after getting wet. His father has spoilt him because of his illness, and says "you never know how long we will have him". Now he is so out of hand, we want him to go to boarding school for 6 months to be quietened down. . . .

'He tells lies, saying boys hit him when they haven't. He's very imaginative and thinks he's somebody. . . .

'He can be very affectionate, often comes and sits on my lap. Underneath all his nastiness and naughtiness there is a nice side to him. He is very good to small children and looks after two little girl twins who live opposite, taking them into their garden if they get out, in case they get run over. If the neighbour smacks her 2-year-old, Tommy runs in and smacks the mother saying "She only has a child's mind, you should talk to her, not smack her". He is very generous to other people. He prefers older boys to play with and they don't want to be bothered with him. He once said "You are too mean to give me a baby"....

'Since living in X—he has mixed with a very rough crowd and swears horrible. Jean who is a real church girl and loves church, gets very shocked....

'He often wakes up in the night, but isn't afraid of the dark or the lavatory; jeers at me for being afraid of mice. If he wakes up he will often get into Jean's bed. He's not afraid of threats and says "You say you will hit me with a stick but you won't"....

'I never know what he will do if I let him go out by himself. My husband's father says that if Tommy had been left to me entirely, he would not be any trouble now.'

Mrs. T. said that a friend had had similar trouble with her boy, and tuberculosis of the bowel had been found. She was very glad that the hospital had admitted Tommy and investigated his case thoroughly, but when Tommy came to the clinic he said to his mother 'I know you are going to leave me there—why don't you tell me the truth now?'

Examination

R.S.B. Form L. C.A. 6.3; M.A. 6.5; IQ 105. Tommy was not retarded in arithmetic but was unable to read the simplest words. He refused to come alone and asked for his mother, being afraid that he was going to be kept in hospital. He accepted reassurance and talked a great deal. His interest in the test was fitful and in spite of the presence of the neighbour who had come with them, his mind was constantly reverting to his mother.

He was small, stoutly built, with a red face and a hoarse voice. He came in with a whine, 'I want to stay with my mummy,' but was quickly persuaded to stay after he had seen the toys. His speech was very indistinct and babyish, partly due to an exceptionally high arched palate. He said how much he disliked his present school 'the boys push you over'; but he preferred living at X—though his sister liked London best. He did not want to have any more brothers or sisters. He had 13 Dinky toys and a big boat which he had not yet sailed. He then showed how to pull the tyres off a Dinky car and became very confidential in his talk. He described being bitten by a puppy, and boasted about going to the barber's by himself and so on. The interview was very long.

Mrs. T. appeared to be rigid and lacking insight. The soiling had become intolerable only after removal of tonsils as an out-patient. At one time soiling had occurred 4 to 6 times a day, but now about once every 2 to 3 days. He was bullied by the boys on the new estate who, she thought, were demons. 'Although the houses are nice the children are vile.' She regretted the loss of the comparative quiet of down town London.

Mrs. T. thought Tommy disliked school because of the long day and he hated

school dinners which he was made to finish. He used to cry before going to school, saying: 'I will escape.' She said that the headmaster was not helpful; she had a low opinion of the school, a Roman Catholic Church school, but sent him there because Jean could take him on the way to her own school.

At home Tommy's bravado and bullying of his sister worried them. Jean had been very delicate, with long spells in hospital and convalescent homes. She was quiet and good, and was shocked by Tommy's noisy, rough, difficult and demanding behaviour. However, when psychotherapy was suggested Mrs. T. replied by letter that the only useful service the clinic could render would be to send Tommy away from home 'so that he would learn how to behave himself'. They did not attend and a follow-up letter was not answered.

Comment

In Tommy's case a disturbance of the control and expression of aggressivity stands out as a first point of enquiry. In this there were two paradoxes: first, Tommy was both bullying and shrinking; second, he was then soiling, whereas previously he had been excessively clean.

Tommy's troubles had a 'second-year' air about them, but the family difficulties must have started before then. The parents were an unexceptional couple, fond of their children, and the mother thought that the father's over-indulgence was a fault on the right side. The first shadow on this family was cast by Jean's attack of rheumatic fever, the gravity of which was underestimated at first. Jean became subdued, quiet and over-good and was quite unable to cope with Tommy's later aggressiveness, which made his behaviour appear worse than it really was.

Preoccupation with Jean may have caused Mrs. T. not to notice that all was not well with Tommy. She gave an example of her lack of perception in relating that Tommy 'was not at all frightened of the dark', but when he woke in the night he would creep into Jean's bed. It is possible that she failed to notice disturbances caused by Tommy's three periods in hospital during his first 2 years.

There is no record of any first-year troubles, but Mrs. T. would have controlled the situation rigidly. She met Tommy's basic and primitive needs, but their relationship failed to develop beyond the weaning and other training experiences. Tommy was never quite satisfied, but his mother's control would have been too rigid to allow of expression of dissatisfaction. He had conformed well to her obsessional toilet training, and for a time he appears to have been over-clean and over-careful. The conflict in Tommy's mind seems to have been between over-dependence and stifled individuality, and was provoked by incompleteness of satisfactions. The existence of this conflict was revealed $2\frac{1}{2}$ years later when Tommy started soiling under the impact of developing social life and of increasing necessity to be independent of his mother. It was an aggressive symptom, too, because Mrs. T. particularly abhorred dirtiness. It is remarkable how often an aggressive child's symptom is something that is particularly repugnant to the mother.

The paradoxical situation developed slowly. Tommy was over-controlled, and expressions of independence or aggression against his mother would have been crushed by maternal displeasure. Since there was little warmth of maternal relationship, maternal displeasure evoked by Tommy's aggression would have been painful for the latter.

Tommy's over-control deprived him of experiencing trial and error, finding out for himself, learning to control his own feelings, and of the enriching experience of making a mistake and being rescued lovingly by mother or father.

As he grew older, his out-turning temperament caused him to react to dissatisfaction by increasingly aggressive, seeking, demanding, jealous behaviour. As he grew further away from his mother's control, two sides of behaviour developed. At home the essential healthiness of his basic relationships enabled him to show his worst side; he was difficult, unreasonable, aggressive, often violent and horrid to Jean. He had learnt that no terrible consequences would ensue from such aggressiveness; that when he became too violent, his mother could probably control him to some extent. Uncertainty, however, made him experiment constantly to see how far he could go.

Away from home he was fearful, timid, unable to stand up for himself, would come home crying and cling to his mother. But no child can be wholly nasty, and Tommy poured out the positive side of his nature on to younger and weaker children, which greatly redeemed him in his mother's eyes.

The soiling was a combination of aggressiveness towards his over-clean mother and regression to a toddler behaviour standard. It might be regarded as a loud appeal for help, an appeal that practically destroyed what remained of his mother's tenderness. His parents despaired of success; lost confidence and looked for a *deus ex machina* in the form of a boarding school for him 'to be quietened down'.

Martin B. (57) 5.6 years

Martin was brought to the clinic by his mother after a Parents' and Teachers' Association meeting. She complained of his irritability, unmanageability, temper tantrums, jealousy and aggressive behaviour alternating with fears.

Martin was the older of two children of young middle-class parents. He was a wanted child, born 1 year after marriage. Pregnancy and confinement normal. Martin was bottle fed from 2 months, because of his mother's breast abscess. She thought breast feeding was 'a nasty messy business'.

He was a lovely, happy, though quiet baby. Teething started at 6 months, walking at 15 months, talking quite well by 2 years; nappies discontinued at 15 months, toilet training complete by 2 years. His mother employed a rigid Mothercraft system and both parents set high standards of toilet and table behaviour.

Martin was prepared for Linda's birth when he was 3. He stayed with friends for 3 weeks and seemed happy except during his father's visits. Martin showed much love for the baby at first, but jealousy later, and his parents noticed a stammer.

After the age of 3 the characteristics complained of gradually developed; his moods tended to swing from excitability to moroseness; he became touchy, secretive, and at times his parents thought him excessively silly. His touchiness was mostly with his sister, who became provocative as she grew older; in contrast, Martin would give anything to the 2-year-old girl next door. Martin had a teddy bear whom he treated as a living human being. At 4 he had 6 days in hospital for tonsillectomy, and came home 'a bundle of nerves'.

Martin's behaviour at home can be well illustrated by an example: one day some friends came to tea, and his father refused to let him have the last cake. Martin was very angry and shouted: 'Naughty Daddy—I'll break your glasses—I'll scratch you

—'I'll pinch you' and a terrible temper tantrum developed. One of the friends remarked 'Linda loves her Daddy'. Linda then went and sat on her father's knee. Martin flew across the room hitting at Linda, and tried to pull her away until the friend called Linda to her; Martin, protesting loudly, sat on his father's knee, a moment later he flung his arms round his father's neck and said: 'Daddy, I want to love you.'

Almost every mealtime became a battleground, ending in Martin being sent out in disgrace. Once he shouted to his father 'If you don't hold my hand I'll *do* something'. His father, who was a hearty man, attempted to toughen him; made him play cricket with a hard ball and romped with him. Martin was unable to stand this and collapsed in terror. His mother thought that he was humourless and could not take any joke, but at school he was fearless and the bully of the class.

When Mrs. B. was ill, Martin was particularly difficult with his father. Once when his mother had sent Martin upstairs in disgrace she overheard him say: 'I wish Mummy was in prison; I wish she could go away and not come back.' She pacified him, but next day she was out all day and Martin became very anxious and made a great fuss when she came back: 'You won't go away, will you?'

One constant aspect of his behaviour was that no matter how naughty he had been all day and how much hate he had displayed towards his mother, he would never go to sleep at night without a reconciliation. The last half-hour was usually spent in making reparation.

At school he settled slowly and wanted his own way. He was good at practical work, but had to be first in everything. He was exceedingly literal minded and went in much for games of retribution and punishment. With the other children he was quarrelsome; he hated being punished if the other children knew, and was full of bravado. The school noticed that he had a sense of humour when understood, and that he responded best to kindness and to being treated as a grown-up.

Two months before referral he moved to a bigger school, where he was noisy, aggressive, resenting authority, rude and disobedient. The other children disliked him and he made unprovoked attacks on them. His stammer became worse, but he also showed an intelligent interest in his work.

This family lived comfortably in a residential suburb. Mrs. B.'s father had been an engineer who had retired abroad, and her parents had been separated for some years. Mrs. B. admired her father for his great strength of character and was deeply identified with him. She spoke contemptuously of her mother whom she regarded as very dependent, because she preferred to stay with her own mother rather than live abroad with her husband. Mrs. B. blamed her mother entirely for the break-up of her parents' marriage. Unfortunately for both parties, the old lady was now partly dependent on Mr. B.

Mrs. B.'s own marriage had been happy, but paradoxically, when she developed her breast abscess she was angry that her mother was away at the time and said petulantly: 'I only had my husband to help me.'

She had expected much from Martin and she was a great believer in discipline. She said ruefully that her own father had been abroad and she had never known a father's discipline herself. She had never felt able to demonstrate affection to her baby because, she said, her own mother had never really loved and kissed her.

At times Mrs. B. did not know how to contain herself over Martin's rebellious-

ness. Later, she associated her anxiety with an incident when her own mother had flown into a terrible passion, and attacked her brother with a stick, temporarily dazing him. All aggression or roughness made her anxious and when her brother had recently remarked: 'Martin is just like Mother', Mrs. B. had been most disturbed. In contrast, said Mrs. B., Linda 'is all over me and ready to do anything for me'.

Mr. B. was the second of three sons of a patriarchal father. He had had a conventional education, and had become a branch factory manager of his father's machine tool business. He took an active part in the up-bringing of the children. Mr. B. was a mixture of boisterousness and obsession. His desire to have a manly son led to much rough play and romping; but his insistence on good behaviour and obedience led to continual nagging, especially at mealtimes. He was thoroughly disturbed by dirt or disorder and had annoyed his wife by buying a strip of drugget because of the children's dirty footmarks. His idiosyncrasy had led to a number of awkward situations, but the parents' mutual love, had prevented a major misunderstanding.

Linda was pretty, a forward and attractive girl of 2½, who was made much of by everybody. She was just as good and sweet as Martin was difficult and naughty.

Examination

Martin was a well-grown, healthy boy. He was terrified, suspicious and very disgruntled at his first visit. In spite of doubtful co-operation, with the R.S.B. Form L., his IQ was 120. Further description of Martin will be given in Chapter 19, where his progress under treatment will be outlined (see page 442).

Comment

Both Tommy T. (56) and Martin were suspicious, lacking in humour and had a fear of not being loved. People thought of Martin as being undisciplined, and this was true in the sense that he was unable to control his own tumultuous emotions. However, he had been subjected to unusually strict parental discipline since earliest childhood, and all independence or revolt had been suppressed. This automatic parental suppression of his slightest hostility had left him unable to control his natural impulses for himself. His parents had handicapped him with the kindest possible intentions, but they were bound by the shackles of their own childhood.

The key to Martin's fear of not being loved, his suspiciousness and bravado, his dependence and resentment of help, and his inability to be aggressive even in play with his father, was in his parents' own childhood. Mr. B.'s strong identification with his own father had resulted in his over-scrupulous and conventional character. He could not tolerate hostility in his son because of his repressed hostility to his own father.

Mrs. B. was guilty over her hostility to her own mother, and to her, also, hate in the parent-child relationship was a source of intolerable anxiety. Both parents, therefore, met any show of naughtiness by Martin with acute anxiety and automatic suppression.

However, there had been difficulties before Martin became aggressive. Mrs. B. could not bear breast feeding; starved of maternal affection herself, she could not give herself wholly to her child. The first year was relatively trouble free, but the repressive régime of the second and third years not only undermined Martin's

security, but his resistance aroused deep anxiety in his parents, at a manifest level that he would turn out like his grandmother, and at a latent level that he would express the hostility that both parents had inhibited.

Linda's birth was too much for Martin's state of undermined security. His insecurity, expressed as jealousy, provoked more parental anxiety. In addition, the apparent withdrawal of parental love implied in his relegation from first to second place in the home, to which his few days in hospital would have contributed, faced Martin with the main inference of not being loved, which is of not being lovable. Martin's reaction may have been one of despair. He had not had enough help from his parents to enable him to control his feelings of hostility, himself. His nightly reconciliation with his mother showed his anxiety; he could not entrust himself to sleep, the symbol of death, without resolving his guilt about his hostility to his parents. It was significant also that he asked for control: 'Hold my hand or I'll do something.'

Martin would try to be good and always failed, either because of uncontrolled impulses or of parental misunderstanding; the resulting row proved his badness to him and he would give way to rage and despair. This vicious circle of remorse and unsuccessful amends went on, without prospect of improvement.

Martin's fearless, dare-devil behaviour at school, where his emotional security was less involved, contrasted with that of Tommy, who with a weaker reaction pattern and poorer basic relationships, could be aggressive only at home, but was whining and babyish outside. At school Martin could do something to prove himself worthwhile.

For consolation and proof that he could be good, kind and loving, Martin like Tommy, turned to a neighbour's daughter and also to his teddy bear, on whom he lavished affection without jealousy.

Hope lay in Martin's increasing co-operativeness at school, and in the very robustness of his reaction at home. His lively affective relationships and intelligent parental co-operation gave his case a good treatment prognosis; and so it turned out.

IN-TURNING REACTION

Derek G. (58) 9.8 years

Though it always seemed improbable, it was alleged that Derek was difficult in school; he would work only when a teacher stood over him; he was very obstinate and sometimes quite cruel to smaller children. Once he was supposed to have been accidentally tripped up by a smaller boy, and then 'callously' to have knocked the other boy down.

Mrs. G. complained that Derek had no persistence in difficulty. He never finished anything, would get out toys and would not put them away, after doing nothing with them. His mother was worried most of all about nocturnal enuresis. He had never been reliably dry, but had occasional short spells of dryness. In the main he had been encouraged by rejoicing over a dry night, and she said that he had never been punished. The wetting was as a great cloud over the family life, and Derek was deeply troubled by it himself. The family lived quietly and comfortably in a residential suburb, and was very respectable.

Both parents felt rather old for their children. Father was 42 when Derek was

born, mother was 39. Mr. G. was a business executive, a big man, inclined to severity with Derek, whom he thought not manly enough. The father worried that Derek seemed 'out of control' at home, though the maximum evidence of this was Derek's refusing to put his toys away, and his bedwetting. He felt that his wife 'spoiled' Derek, to which her stock reply was 'it's easy to be critical when you are not there yourself, seven days a week'. Mrs. G. was a careful, most conscientious person. She was aware of fussing over Derek, because she felt he was lacking in comparison with his brother. Before marriage she had been secretary to a company director and always enjoyed working. In order to keep up some interest 'outside the four walls of my house' she undertook local welfare work, and also helped with dinners at Derek's school. She liked children best as babies: 'What a pity it is they have to grow up!'

The mother's tremulous manner gave an impression of one who was neurotic and ill, but this was erroneous. She was healthy, strong and never complained about herself, but she was eternally defensive and anxious about the health of her family.

Charles, who was 4 years older than Derek, was a clever, successful, go-getting boy who was doing well at grammar school. Apart from squabbles, the brothers were very loyal to each other.

Charles was born 9 years after marriage, and Derek 4 years later. Pregnancy and labour easy, breast fed for 7 months, weaning easy. Derek was not particularly faddy over food, but was not fond of meat. Walking and talking were normal. He had always had trouble with his teeth and wore a brace to straighten his incisors. He was very sensitive about his appearance. His health was good.

Toilet training had loomed large; Mrs. G. was anxious, though not severe over it and he was clean early, but never dry at night. Mother and children were twice evacuated together for 2 months when Derek was tiny. Derek had been frightened by the flying bombs when he was about 4.

Mrs. G. said that Derek was most generous and affectionate, 'he would share even his last sweet'. One day he noticed that she was tired, fetched aspirins and made tea. But there was a 'black side to his nature'—mainly obstinacy and unsociability. He made friends at school only among younger boys. He tried to get out of Cubs because he was afraid of the rough boys, and he avoided tests. His main interest was playing with water, which amused his mother. He did not like being alone in the house, but otherwise was reasonably independent. There were no troubles at night. The mother said that he whistled on his solitary way up to bed in order to keep his courage up, but it might be asked what proportion of 9-year-old boys are expected and will consent to go upstairs to bed by themselves.

His headmaster had promoted him to a higher class in order to encourage him, but without improvement. His school report stated: 'His behaviour in and out of class is most unsatisfactory unless continually supervised. With other children he does things in an underhand way and puts blame on others, and will seldom own up. . . . There is deep concern both at home and at school because his brother, now at grammar school, was brilliant.'

Examination

R.S.B. Form L. M.A. 11.4 years; IQ 119. The scatter was long and irregular due, probably, to an over-critical attitude. He was well above his age level in abstract

verbal material. It was considered that the test result might be a slight underestimate, and that his poor showing at school was related more to his attitude than to his assets. He seemed to lose his nerve very quickly, and was too anxious to listen properly to his instructions, in several of the test items.

At the first psychiatric interview he was shy, timid, and apologetic. There was no evidence of aggressiveness, spontaneity or vitality. He tended to agree with anything that was said to him, said he did not like tests at school, especially English and arithmetic. His hobbies included handicrafts and at home he made miniature model boats. He played at sinking the Queen Elizabeth by submarine, and similar war-like games—he would like to join the navy and be a sailor when he grew up. He had fantasies of ships and the sea, but never dreamt; he used to be afraid of a burglar under his bed but huddled under the bed-clothes and would go to sleep. He said he liked making up stories and intended to write some autobiographies of oak trees, an old boot, and so on.

He treated his bedwetting as a guilty secret between his mother and himself. He said that he felt sad when things went wrong at home; that he was to blame when his mother looked tired.

His mother also displayed much guilt; twisting every remark into a well-merited reproof. She maintained that he was not timid, and preferred to think of him as rather a desperado. It was concluded that Derek was compensating for his aggressiveness by solicitousness, and for his guilt by seeking punishment. He had also inhibited curiosity.

Owing to pressure on the clinic, 6 months elapsed before treatment began. At his next visit he was friendly and excited, and talked volubly rather than played with toys. He mentioned his bedwetting freely and said: 'You know, I think I worry a lot.' He worried especially about the cat at night.

His bedwetting occurred every night, sometimes before being lifted at 11 p.m. His other problems were unchanged.

Early in treatment Derek preferred to draw, at first copies, but later he drew one of his recurrent fantasies. It depicted a well-made suburban house, with another alongside under a penthouse roof. The little house was, except for one small window, an identical copy of the big house. Every scrap of paper was covered with paint. It became obvious from his fantasies that the picture referred to his relationship with his mother; his mother, the big house and himself, the little house.

Derek and his mother were meticulous in their observance of the treatment regimen. He was diffident at first, he drew and said he did not want to miss exams at school. Then he became freer, played quiet, sedentary games, especially with model villages in the sand tray. He once played a half-hearted game of skittles, with embarrassment. After several months he played stump cricket and became competitive. He started a big jigsaw puzzle, and had the fantasy that he would be cured when he finished it. In fact by the time he had finished he was wetting only very infrequently. Direct interpretations were made and his play became aggressive and he verbalized his jealousy of his brother and fears of his father. At the end of treatment period he had become constructive; he was a keen naturalist and brought flowers for discussion. He became permanently dry 8 months after treatment started.

Unfortunately, he failed his grammar school entrance examination. Possibly if he had made this improvement a year previously and had a year of more integrated

behaviour at school, he might have passed; but his improvement came too late.

Comment

Derek's mother fixation might have been ascribed to an unresolved Oedipus situation, were it not for his pre-oedipal enuresis and his mother's anxiety very early on.

Mrs. G. took marriage and maternity very seriously. She was conscientious, moral and rather humourless; sensitive, but comparatively uneducated. Her husband was very different; a successful self-made man, no more cultured than his wife but lacking her sensibility. He was a devoted husband and father, but insensitive to emotional need and intolerant of failure.

Mrs. G. remarked that Charles arrived when she had given up hope. Charles was a go-getter from the start, an active, thriving child who became smug in adolescence and was not likeable. Mrs. G. was at her best with tiny babies and by the time Charles was 4 he had already got beyond her. She poured on to her second baby all the feeling of a woman deprived of the tenderness in life that she needed so much.

War broke out when Derek was 17 months old and Mrs. G. reacted with great anxiety. She left London with her children, like thousands of mothers, in the mood that she would never see her husband again. She was miserable during the 2 months of evacuation, which unfortunately was the critical time of Derek's toilet training. After returning to her Air Raid Warden husband, the uncertainties of the 'phoney war' culminated, for her, in another evacuation when Derek was 2.4 years old. He was not yet dry and she lost her nerve. Charles, now 5, took to the village school and became a successful, independent, schoolboy. Perhaps Mrs. G. did not really want Derek to become independent.

As the years passed by, both Mr. G. and Charles attained success, and Derek and his mother became the unsuccessful and dependent wing. They came together in a defensive alliance, the basis of which was anxiety about change, and in particular about Derek growing up.

Keith J. (59) 3.8 years

Keith was referred for poor eating and sleeping, nail-biting, aggressiveness to his younger brother, and an obsession with figures. The family lived comfortably in a suburban house and garden, opposite the paternal grandparents' house. David was 18 months younger than Keith, and a third baby was expected in 5 months' time.

Keith's father was 30 years of age, rather tense, of youthful appearance, well turned out, a sound engineer with good professional qualifications. He said that his interests had broadened during the war and since then he had become more musical and more religious. He thought himself conscientious and worrying, and had sought reassurance about the latter from a psychiatrist while in the army, in which he served for 6 years. He was an only child, but when 3, his parents had adopted a 3-year-old boy, and the boys did not learn the true position until they were 17. The only known source of stress in the father's childhood was the paternal grandfather's anxiety. The latter had been a psychiatric casualty of the First World War, and in 1932 this grandfather had a further 'nervous breakdown' of a depressive kind. He was an unsettled person who had held a variety of open-air jobs and was still a jobbing gardener at the age of 70.

Mr. J. had always been much under the influence of his own mother who was an

energetic woman in her sixties, devoted to Keith, and giving him all her time when he was in her house. She was inclined to 'manage' the children, even in her son's house.

Mrs. J. was a well-educated, well-dressed, sensible woman. She met her husband while in the army during the war. She had two sisters and a brother; her mother had died some years previously, but her father, who was a small-holding farmer, died shortly before Keith's birth. She felt that she was less conscientious than her husband, but that she was by nature anxious to do the right thing always.

Keith was a wanted baby; pregnancy uncomplicated; labour easy, birth normal, weight 9 lb. Mother and child enjoyed breast feeding, which lasted for 8 months. Weaning was gradual, and he did well until one year old, when he seemed to lose interest in his food, which Mrs. J. connected with the father's demobilization and setting up a family home, and her 3-months pregnancy with the younger child. When David was born, Keith went right off his food and hardly put on any weight for 5 months. He took change badly and on a recent holiday had lost his appetite and had been frightened of the sea.

Keith walked at one year but did not talk until nearly 3. He had no teeth at 12 months. He was clean and dry by day at one year but still wet at night at 3 years, and this had been a source of anxiety to his mother who was keen to get him dry. His health was good except for slight catarrh. Keith was rather resentful of his father, who was apt to be impatient with him, in contrast to David, for whom Mr. J. had 'always been able to do everything'.

These worried parents discovered the name of the clinic in the telephone directory, and then were seized with doubts about their action which they uneasily justified by the imminence of the new baby. Then it appeared that the paternal grandmother was at the centre of the problem. They were quite preoccupied with keeping Keith from going 'over the other side' to his 'nanny'. Mrs. J. was also apprehensive about leaving Keith and David together. Meals were a constant difficulty and Mrs. J. spent a lot of time coaxing Keith to eat. The father was in a quandary, duty urged him to support his wife, but his own and his mother's inclination was to take the easy way with Keith, who knew well how to play off one parent against the other.

The father wanted Keith to go to nursery school full time, but was anxious lest he 'overstrain his brain'. He said that Keith was fascinated by numbers. Keith knew all the bus route numbers and exactly where the buses went. He was always scribbling numbers, which seemed to be his greatest interest.

Examination

The psychologist's report stated: 'Keith is of very superior intellectual ability. On the Merrill Palmer Scale his first failure occurred about at his chronological age level, while he still had two successes at year 5. . . . He quickly became absorbed in each item and seemed to derive satisfaction from completing the tasks. He worked very methodically: C.A. 3.8; M.A. 4.9. R.S.B. Form L. M.A. 4.11; IQ 134; P.R. 98. Basal age 3.6, scatter up to year 7. In both tests he occasionally was dependent, saying "What do we do here?—you do it for me"; or "Where does this go?", and would also assert obstinately that he could not do without help. He disliked the examiner turning away, even for a moment, and stopped what he was doing until he had full attention again.'

The psychiatrist reported that he was a good-looking child with a very composed manner, very observant, quick to pick up meanings, and appearing intelligent from his manner. He seemed interested in the toys but did not move to play with them. When pencil and paper were suggested he settled down happily to scribble letters and then spontaneously drew a picture of bus routes near his home. This might have gone on indefinitely and he appeared really to enjoy manipulating pencils and paper. He more or less lost touch with the doctor, was self-contained and at ease. He was not completely cut off but was quite willing to talk when his attention was gained. He described his house, his family and 'nanny' who lived 'over the other side'. He was very definite that he would like to sleep in a room by himself, and as he said this he broke the point of his pencil by sudden extra pressure, which might be regarded as the communication of feeling into activity. He was visibly upset by this mishap, and looked around as if seeking some way out of the difficulty—some way of repairing the damage. When asked whom he liked best in the world he replied: 'Mrs. Guest who lives over the road.' It was not discovered who Mrs. Guest was. He said that David was at home asleep. Though he was visibly tense, he appeared capable of entering into friendly relationships with a stranger, and of adapting himself to the needs of the social situation.

The parents were seen together at this interview. Mr. J. was the more tense. Mrs. J. thought that her pregnancy accounted in part for a recent worsening of the problem. She was frankly irritated by the strong link between the grandmother and Keith, and was extremely critical of her mother-in-law.

An additional worry at home was Keith's roughness with David. He used to hurt him quite often, but at other times was protective and loving.

Family tensions were such that they were looking for a house about half an hour's bus ride from the grandparents—just far enough away to make it rather a trouble for the parties to visit each other.

Comment

These parents were careful, conscientious, loving and united; and there were no apparent underlying difficulties. We need to consider first, heredity; secondly, the style of life of the family; and thirdly, the possible influence of certain events in Keith's early life.

First, the paternal grandfather had never fully recovered from his war neurosis, and the father, who was born in 1920, had grown up in an atmosphere of worry. Mr. J. had good insight into his own mildly anxious state of mind, but it was clear that at the age of 30 and even after military service, he was more than usually dependent on his dominating mother. However, parental anxiety will contribute to the environment atmosphere rather than to the genes of the baby. There was no evidence of neurotic traits on the maternal side, and, in any case, there is little or no evidence that even a severe neurotic tendency can be inherited.

Secondly, the family style of life was set partly by Mr. J.'s mild anxiety and over-dependence on the grandmother and partly by the mother's anxious watch over Keith during early infancy without her husband's support, but determined not to seek help from her mother-in-law. This influence, unusual in the sub-culture, that the grandmother exerted, would have been even more divisive had the mutual loyalty of the parents been less. This family looked as if it ought to have been able to

provide a favourable environment for a child's development. There was no evidence of difficulty until Keith was 12 months old when his father returned permanently, and they separated from the grandparents, and Mrs. J. was 3 months pregnant.

Many mothers will tend to withdraw slightly from their older child when they become pregnant again, and in this case such a tendency may have been increased by the father's return home and her increased need of her husband early in pregnancy; and by their removal to the first home they had to themselves. Keith's affections during his first year had been divided between his mother and his grandmother, and in one cataclysm he seems to have lost to his father and the new baby, something of his mother's love, and the solace of his grandmother too. He went off his food, but his depressive withdrawal went much further than loss of appetite. He gained no weight for 9 months. Though he walked at 1 year, he did not talk until 3. He was clean and dry by day at 12 months, but not by night at 3½. He had evidently seriously rejected growing up.

In order to determine the level of Keith's fixation it is important to enquire whether his withdrawal was of oedipal origin, i.e. a reaction of a mother-fixated boy to the return of his father; or of more primitive origin, i.e. clinging to an unsatisfying maternal relationship. Since it appeared first during the early part of the second year, Keith's reaction was probably one of clinging to infancy, refusal of new developments and the inhibition of oral aggressivity, leading to the inhibition of aggression at an anal level, too. The effects of the repression of aggression at an oedipal level will be described in Chapter 12.

The effect of rejecting growing up can be seen in Keith's toilet training. He responded to daytime training which was closely under his mother's control, but not to night training which had to be his own responsibility. Instead of sublimation he had developed only reaction formation against dirtiness and aggressiveness, even in the socially permitted and instinctually necessary biting of food. He had become over-particular, over-controlled, and subject to fears. His natural aggressivity had largely disappeared, he was timid, slow and unadventurous, and he hated change. His reaction formation was at a primitive level of non-appearance or non-experiencing of aggressiveness rather than excessive control of formed feelings and drives.

No such reaction can be absolute, and Keith's slight capacity for aggressiveness was shown in being horrid to his brother at times, and in nail biting. He had enough security at home to be slightly aggressive towards his brother, but his nail biting was more neurotic; being compounded of futile aggressiveness turned inwards, and self punishment. However, even nail biting may be better than absolutely no deployment of aggressiveness.

Keith's obsession with figures represented a more positive, organizing type of response to difficulties, a type that will be described more specifically in the next group of cases. Another equivocal sign of development came later, in his capacity to love the new baby. Such evidence of capacity to love can have a strongly reassuring effect, but to split love and hate between siblings can also lead a child into emotional conflict and potential neuroticism.

SPECIFIC SECOND-YEAR PROBLEMS

The four preceding cases illustrate general second-year problems. In practice

the clinical phenomena are usually more specific and more restricted to certain marked symptoms and signs. For example, the child will show a marked development refusal, or perhaps specific toilet training difficulties or severe difficulties of control of aggression, whether in the direction of unmanageable temper, inhibition, over-control, or obsession.

The clinical picture is usually complicated by later additions. Regression nearly always occurs and, as a result, further difficulties will probably arise from the environmental pressure upon the child to make up the deficiency and from the child's own attempts to control the situation. For example, as will be illustrated below, an obsessional reaction pattern may represent both a child's rigid defence against strong parental pressure and his attempt to gain control of an unruly environment. An obsessional reaction will usually create more difficulty than it resolves, and the original condition will become obscured. Then again, the child in difficulties is liable to pick up additional sources of strain in later development periods. *Rodney's* (60) maladjustment originated in the first year, at weaning; was at a peak during the second year; but was later augmented and complicated by an unresolved Oedipus conflict that dominated the clinical picture. *Roy's* (65) presenting symptom was stealing, which could not possibly be a second-year problem, but it derived from character formation difficulties of the second year that prevented the development of moral and social attitudes which engender honesty.

INHIBITION OF AGGRESSIVITY

Rodney H. (60) 9 years

The school medical officer wrote: 'This boy complained that boys were running after him in the street. He could not see them, but he could hear them. When asked why, he said because he ran after boys once when he was at woodwork. He says he has pains in the side and stomach. He gets a feeling of a lump in the throat. He cries a lot at school, is not happy, will not stay for school dinner but must run home to mother. . . .'

The headmaster of his junior school reported: 'He is a neat and tidy worker, well above average; his behaviour is good in and out of class; he is courteous and attentive to lessons, sociable with other children. He is inclined to be a little too sensitive—does his mother fuss over him unduly?'

The school welfare worker wrote: 'Mrs. H. is an extremely pleasant woman of nearly 50, who still suffers from the effects of this birth. The home is very neat and clean; Rodney sleeps in the "best room" on the first floor; the parents sleep in the ground floor living-room. The maternal grandmother also lives with them and is very devoted to Rodney.

'It is obvious that Rodney is too much attached to his mother, and she partly realizes that he is not like other boys and is "almost too good". She wonders if she is sometimes too harsh with him. Her own brother died at 13 and her mother urges her never to deal crossly with Rodney as she has never forgiven herself for scolding her own boy. At the junior school a great trouble has been that he has not been able

to come home and see his mother in the dinner hour and he cries at school because he cannot bear not to have seen her at dinner time. The boys are rough in the playground and Rodney is afraid of them.'

Mrs. H. married at the age of 23 against her own mother's advice. Mr. H. had been invalided out of the army with 'Disordered Action of the Heart' (cardiac neurosis), and had a small pension. He had been a window-cleaner, which is heavy work, for 20 years, but neither parent had abandoned the idea that he was an invalid.

Mr. H. came from a big family in poor circumstances but had had a happy childhood. He was a good husband and father, an affectionate individual, but irritable at times and prone to nervous dyspepsia. He could not play long with Rodney, because of breathlessness.

The mother, at first sight, seemed robust and hearty. She too, came of a big family, 'poor but jolly parents'. She was the oldest living sibling and all the others had big families. She was a very talkative person, whose powerful feelings might perhaps have been more successfully distributed among 5 children than only one; but she worried about little things. Since Rodney's birth her life had been dominated by womb troubles.

After 5 years of marriage, the parents' first child lived for only half an hour. Mrs. H. had hypertension and was advised against further childbearing for 2 years. In fact she became pregnant again 13 years later at the age of 41, but mistook amenorrhoea for an early menopause, up to 20 weeks. She was in poor health for the rest of the pregnancy and was admitted to hospital for the last 2 months. Labour was induced a fortnight late, and was prolonged. No instruments were used; the baby was healthy and weighed 7 lb. 11 oz. Mrs. H. said that her surplus milk supplied other babies too, but Rodney was a poor feeder.

Mrs. H. was much under the influence of the maternal grandmother, Rodney was a cross, crying baby, subject to 'colic'. Of the many conditions covered by this term, screaming is the commonest. Mrs. H. said: 'he was a lazy baby' and she unsuccessfully tried all ways to solve the feeding problem. Weaning was long and painful, first he refused the bottle, then refused solids, and he was 15 months old when given his last breast feed. Rodney had been fussy about food ever since; often asking for expensive foods out of season and then scarcely touching them.

Mrs. H. was proud that she never had a dirty nappy to wash. She kept close watch on his face and would sit him on the pot before the damage was done. He was dry and clean very early.

Teething was late and kept them unhappy. His hair was beautiful and curly and his mother had it cut only at 5, under the threat of school entry. Rodney much resented the frequent repetition of this story and would say 'I'm no girl'. He walked without crawling at about 16 months. His mother remarked about his 'little paddy', when he threw himself on the floor. Until 5 years Rodney scarcely moved from mother and grandmother. He was poor at amusing himself, easily bored and 'fed up', and always had to be provided with ideas. He bit his nails and picked his nose. He had disturbed nights, cried in his sleep, woke up frequently during the night, even at 9 years of age, and then wanted to sleep with his mother.

There were no significant illnesses nor separations. The family was in London throughout the war, and Mrs. H. with one of her rare gleams of humour said that

Mr. H. cleaned the few windows that were left. Like many people greatly pre-occupied by fear and anxieties within, this family seems to have been unconcerned about the real dangers without.

Mrs. H. was divided in her mind as to whether Rodney was a wonder boy or a 'cissy'. His maternal grandmother thought he was perfect, but even she sometimes wondered whether he was 'a proper boy'. He was good, never disobedient, often babyish, sitting on mother's or father's lap and saying: 'Let's have a cuddle.' He rendered many services to elderly people, though there might have been some coercion in this, for his mother had a grating, nagging, rasping voice and was not backward in its use.

Rodney's contacts were mostly with adults, and after a few minutes' playing with children he would come in, throw himself on his bed and say he was 'fed up with everything'. He could not stand up to other children's roughness. For recreation, as his mother expressed it, he belonged with his parents to an Anglers' Club, and spent every weekend fishing, which subject was almost his sole topic of conversation. He was a poor eater but would eat a 'nice piece of boiled fish'. Mrs. H. blamed constipation for his frequent headaches.

At school it seemed that Rodney was always wanting to go home. He was timorous and apprehensive and gulled by every scare story. On school days he would not get up without prodding. Rodney was conducting a quiet rebellion against going to school.

Both parents were indulgent, but with guilt feelings about their lack of strictness, so that there was no real freedom and little spontaneity of behaviour in the home. Their family life was punctuated by Rodney's tiny misdemeanours dealt with ineffectually by his mother.

Examination

R.S.B. Form L. C.A. 9.0; M.A. 10.8; IQ 118; P.R. 86.5. Reading Age 7.7.

Rodney was right handed and right eyed; he seemed unsure of himself during the test, anxious to obtain the psychologist's assistance, and highly self-critical. He sought reassurance and frequently believed himself to be mistaken.

He was a pretty boy, with a neat wave in his hair, clean, and very well dressed. He had gentle manners, was polite, quiet and socially adequate in the presence of two adults. He left an indelible impression of a curious self-assurance and gentleness.

He talked generalities for a while and then decided to draw from memory a picture he had copied at school. It depicted a boy running a race, with a string of sausages hanging out of his pocket, which attracted so many dogs that no one could get past them. Though this whimsy was copied, it showed a trace of humour.

He said that at home his main occupation was watching Daddy do his stamp collection. Mummy and Daddy used to read to him. His school was 'all right but a bit rough'. The Head made them play football with a stuffed sock because of broken windows. He denied a roundabout suggestion that other boys were unkind to him.

His three imaginary wishes granted by a fairy godmother were; at first, vaguely, for 'Mummy, Daddy, and Nanny,' then, 'First, Mummy to get better; second, for Daddy to earn more money; and, third, oh, I'll give one for the cat—I dunno what.'

Mrs. H. at that time was volubly worried about the boy, with no clear conception

why. She said that she did not seem to be able to pull round from her recent hysterectomy and had terrible headaches. Her simple nature was revealed by her self blame—because her own mother lost a boy—‘I don’t like to be too strict with him in case I lose him, too’. She had never been able to cross him or deny him.

Comment

There is no evidence of unfavourable inheritance in this case. Mr. H. was undoubtedly neurotic, Mrs. H. was irrational, impulsive and excitable, and the maternal grandmother had once threatened suicide. But otherwise both sides of the family were composed of numerous and cheerful people.

Mrs. H. had a fantasy childhood memory of a happy large family, but in reality she married at the first opportunity, against her parents’ not unreasonable objection, a man recently discharged from the army, suffering from war neurosis. Her self-described action in using her mother’s further pregnancy as an opportunity to leave home was strange in an eldest daughter supposedly devoted to her mother. Her later return when the latter threatened suicide, might indicate her uneasiness about family relationships.

Though Mrs. H.’s *amour propre* seemed to depend on an imaginary memory of a robust and happy childhood and early marriage, since that time the grandmother had re-established her ascendancy.

Whatever the antecedents, Mr. and Mrs. H. each derived much from their marriage, without undue strain on the other. But when their much-wanted baby was conceived after 5 years, disaster followed. However mature a woman may be, to lose a first baby undermines confidence and security to a degree that may constitute a very traumatic experience for a young wife. Then there were years of infertility, during which Mrs. H. found scope for her motherliness in fussing over her husband. They lived for many years on his window-cleaning earnings in the happy notion that he was a martyr to heart disease.

Mrs. H. was 41 when Rodney was conceived, and they had long given up all ideas of parenthood. Her 25-year-old anxieties were revived, with the added worries of a woman of 41 about her ability to rise to the occasion. Her precautionary rest in hospital for the last 6 weeks must have increased her anxiety.

Her fulfilment was ironic; for she had conceived with difficulty; carried the baby with difficulty and been delivered with difficulty; but she was a perfectly bountiful nurse. Unhappily the niggardliness of life had gone into the child, almost as if by inheritance. Having justified her biological existence at last, she nearly lost her child within a fortnight, by starving him. The situation was tense with internal family anxiety.

Maternal anxiety caused tremendous fussing over feeding and pot training, to which Rodney mainly submitted. Such hostility and aggressivity as he had was suppressed, almost entirely, and caused retardation in development that with such a dominating mother might have passed unnoticed. As often happens Rodney’s neurotic attitude to aggression was marked in the feeding situation. He was fastidious and disliked a mess, an attitude that spread to toilet training to an extent that he became severely constipated.

Inhibition of aggressivity would not have created difficulties that the parents would have recognized until Rodney went to school, had it not been for complica-

tions at the Oedipus stage. These parents were showing some degree of role reversal. The father lacked something of masculinity and the mother had rejected much of the feminine role. Between the two, Rodney had little positively masculine with which to identify. With his degree of second-year fixation, he remained infantile and relatively undifferentiated in sex. Possibly his mother's keeping him in curls helped to stimulate him to some slight degree of 'masculine protest' and eventual partial evolution.

Mrs. H. seemed to be guilty about the death of her younger brother when she was 13, and it might be speculated whether her flight from the masculinity of her own little boy had an echo of a primitive and unconscious mechanism of disguise to avoid the fate of a male member of the family. Her failure to recover completely from the birth of her child would suggest the persistence of strong expiatory feelings.

Rodney went to infants' school with no experience of social life, but he attracted no notice in that protected environment. Likewise, the junior school headmaster wrote about Rodney's good behaviour in and out of class, sociable qualities and keenness; but failed to notice this bright boy's 2 years' retardation in reading. Rodney's true attitude was blurred out to the school doctor and, though exaggerated to a point verging on hallucination, at least indicated severe obsessional worry.

The climax came in the more sophisticated latency atmosphere of the junior school, where Rodney became the butt of the other children's cruelty and when he could no longer escape home at lunchtime for moral refreshment.

Rodney and his mother responded well to psychotherapy (see Chapter 19); the former was enabled to take more positively to his masculine role and to begin to move towards emotional maturity; and the latter to accept a progressively changing order of things.

OBSESSIONAL CONTROL OF AGGRESSIVITY

Leslie W. (61) 7.4 years

The ostensible reason for Leslie's referral was that his educational backwardness was jeopardizing the social ambitions of his parents to send him to a public school.

The problem, as it appeared to the headmistress of his convent school, can be gleaned from her report which, however, revealed so much lack of understanding of the meaning of children's behaviour that it needs critical examination. Accordingly, doubtful statements or errors in interpretation have been italicized in the extract given below, and commented on in parenthesis.

'When he first came at 4, Leslie *could not* make himself understood, he *had no vocabulary* and *was not able* to compose a coherent sentence.' (This was not necessarily true of him at home.) '*He could only repeat the question or the sentence addressed to him.*' (Echolalia?) 'He could name some objects, but *beyond that he could not go*, the rest of his sentence being just a mumble, *understood by no one but himself.*' (If even by himself.)

'He was at that time *suffering from some terrible fear* and would run in fear of his life when he heard his name called in class. He invariably took refuge crouched behind a chair, and the look on his face *had something wild in it.* . . . Leslie did not fall in with

the rest of the class, never interested himself in the work being done but *consoled himself* by walking around the classroom rubbing his hands together and spitting at the other children. These children were in fear of Leslie. . . .

'After a year his social behaviour had improved and the spitting had almost ceased . . . but when we had any public performance on in school he would lose all his self-control and behave most alarmingly. Crowds seemed to *overwhelm* Leslie. . . .

'By the end of another year his reading was up to standard. He developed an unusual flair for clocks and calendars, but for paper and pencil, etc., Leslie had still no interest *therefore his writing has never developed.*' (Lack of interest may not be the only possible reason.)

'Leslie *could* only concentrate for very short periods, but managed to take in and retain as much as the other children. Leslie possesses quite unusual capacity for mental arithmetic, and often gives correct answers without apparent thought; e.g. he can tell in a flash the date of next Thursday week. Leslie's memory is quite extraordinarily retentive. He will give instantaneously the correct names to a dozen or more of the nuns, all dressed alike, whom he sees very rarely.

'Though conduct has improved, he is still very much an individualist. He has an unfortunate *habit of wanting "to get his own back"* and if anyone touches him he has to touch them back, even the walls and the furniture must be *hit back* if he knocks against them.' (He had so little social relationship that his 'habit' was more likely to have been an obsessional or magical ritual than retaliation.)

'During the last 3 months Leslie has lost a good deal both socially and mentally, *due to the stricter discipline required of the 7-year-olds.* He started his bad habit of spitting again, but now has *found an excuse for it*—saying he had some nasty taste in his mouth, which he wanted to get rid of.' (To reject Leslie's own explanation without consideration is mere prejudice.)

Leslie was an only child, born when his mother was 37, and lived with his parents over their large village general store. His parents complained of his unpredictable responses, babyish claims, inability to mix, spells of spitting and shouting rude words in public, fears, e.g. of having his nails cut, or a sudden irrational fear, e.g. of a friend's grand-father clock, although they had two at home.

Mr. W. was pleasant but pedantic and made light of Leslie's difficulties at this interview. He had been partially crippled since birth and had had a chequered career that had frustrated his wife's ambitions.

Mrs. W. talked much of her childhood family. Her father had been 'a brilliant man' and her mother 'something of a beauty'. The maternal grandmother had committed suicide when the mother was 7, after returning to England after many years in the East. One of her four brothers was 'brilliant'; but he, her father and she herself suffered from severe migraine attacks. Her family would have 'nothing to do with trade' and she remarked only half jocularly on her present social status:

Her health was poor, especially headaches which 'knock me out for days at a time'. She was impatient with Leslie. 'I'm not the kind of person to deal with children, I drive myself, but really I want someone to lean on.' Life frustrated her—'there isn't much satisfaction in working hard, since you never seem to get any further'. One felt that she had never really considered Leslie's needs.

Mrs. W. spoke vaguely of illness during pregnancy. She wanted to have a child 'in a way', but felt she was old and that, being wartime, she ought to give more

time to the business. Confinement normal, breast fed 5 months. She alternated between saying casually that he was a happy, easy baby, and complaining of broken sleep because of his nervousness at night. His development was generally backward, he walked at 18 months and talking was still indistinct at 4½.

At 2½ years he had a week under observation in hospital. At 4, a bad attack of whooping cough terrified him and his sleeping difficulties became worse. It was hard to assess the position because Mrs. W. would break off an account and say: 'You see I can't stand it.' While she was busy in the shop, Leslie would make noises to attract her attention; 'he knows he shouldn't do it, but he does it just on purpose.' She felt that the sisters at the convent school had 'done a wonderful job in managing him'.

Examination

At his first visit Leslie was unco-operative; at a suggestion of speed he said: 'I'll be as slow as I can.' He did the test in his own order and demanded many repetitions. He was gay and cheerful and said, on leaving: 'You find some more things for me to do and I'll come and do them tomorrow.' On the whole he behaved like a 4-year-old. R.S.B. Form L. C.A. 7.3; M.A. 5.9; IQ 79. Merrill Palmer Scale M.A. 6.6.

Leslie's attitude was very different when retested 10 weeks later. He settled down quickly but was still extremely distractable, and tended to persevere with part of the test to the obscuring of the whole. He depended upon success and approval, and was evasive and excuse-seeking in failure.

R.S.B. Form M: C.A. 7.6; M.A. 6.6; IQ 87. Progressive Matrices (1947): Score 25; Classification B. Porteus Maze: M.A. 9. Reading (Burt): 7.7. Spelling (Burt) 7.5.

Performance results indicated at least average ability, and his basic school attainments were up to his chronological age. The improved R.S.B. result was, however, still well below average, and at the 20th percentile. This, perhaps, represented his intelligence that was available at school.

Leslie was a small, pale-faced child with a strained facial expression. He greeted the psychiatrist by name and used it repeatedly, uncommon in a 7-year-old. He formed a very patchy relationship, with a poor grasp of the realities of the situation. He was dependent like a much younger child, slow moving and slow speaking, but out-turning and apparently immediately verbalizing all his thoughts. In this and in his level of conceptualization he might have been a 4-year-old.

He quickly became bored with free play and showed no imaginative capacity. He giggled when talking about some naughty boys at school and got involved in a long and disjointed narrative of some rich boys at school who did not trust one of the nuns. He was happiest in the execution of a drawing, slowly and methodically with his left hand, while sucking his right fist. This was a pedestrian affair of a house and telegraph wires, done with obsessional care and rubbings out.

He showed a trace of humour and expanded a little with approval but, again, like a 4-year-old.

Mr. W.'s frank concern was to get some educational advice, and then depart in order to complete the Christmas shopping. They wanted Leslie to go to one of the biggest and best known public schools. Mr. W. complained that Leslie could not concentrate on written work, but he was 'brilliant' at oral number, and good at

telling stories. He thought that home life, over the business, had prevented Leslie, who was friendly by nature, from finding anyone to play with.

In an exchange of letters over a period of 4 months, this fussy and pedantic father disputed every suggestion made by the clinic. Finally Mr. W. wrote that he had taken the advice of the County Education Officer to send Leslie to the village primary school in order to get a grammar school place at 11+, and then transfer to a public school at 13+—'when the educational insurance policies will mature'. Mrs. W. wrote independently by the same post: 'My husband has decided to send Leslie to the village school, so my efforts to secure a good start for my son have come to nought. . . . I am certain my husband does not intend to send Leslie away from home if he can help it.' They agreed only in profusely thanking the clinic—for nothing, it seemed.

Comment

Leslie was, perhaps, little more than a pawn in his parents' interpersonal difficulties. Mrs. W.'s current status contrasted sadly with her childhood fantasies. She felt too old and too busy for motherhood. Leslie's motor development was retarded out of proportion because of Mrs. W.'s failure to give him adequate warmth and security during infancy. She could not enjoy her child and did not look forward keenly to each succeeding development.

Leslie went to his first school apparently with the social attitude and emotional equipment of a child of less than 4 years of age, and there underwent a serious regression. This showed them all up in a public and unfavourable light; Mrs. W. candidly wanted him away at a boarding school 'to give him a good start', as she told herself.

The father's attitude was equally egoistical; he felt, though perhaps not so keenly as his wife, that he had come down in the world, and his hopes were pinned on his son's future. He did not, or would not, notice difficulties, until Leslie's school failure brought him up with a jerk. Then he was prepared to embrace any hope, real or fantasy; *vide* his understanding of the Education Officer's advice that it would lead towards the fulfilment of his social ambitions for his son. He rejected all advice that did not appear to lead towards a public school.

About one year later, Leslie was accepted by a small independent choir school, on the basis of a good voice and no entrance examination. Unhappily for the boy, his father could not recognize that the dead end of an independent choir school is a trap for the unwary.

Leslie's obsessional reaction pattern came from a serious defect of control of aggressivity that had caused his extreme retardation of development. He gained little advantage from undergoing the great instinct modification experiences without the warm support of an understanding mother, and was very inhibited and retarded. But in addition, he had become rigid and unadaptable in social behaviour. His obsessional and compulsive behaviour was misinterpreted as fear; his walking round the classroom rubbing his hands and spitting as self-consolation and aggression, respectively. The latter were much more likely to have been ritual magical gestures and obsessive-compulsive acts.

Such obsessional acts often represent inappropriate attempts to control or bring order into an uncontrolled or chaotic environment. A once appropriate gesture in

different circumstances, especially if rhythmic or repetitive, may later become like a talisman, and this is especially true of objects that the child will clutch. Leslie's hand rubbing may well have been a ritual compulsion, and almost certainly his retouching of the walls and his automatic retaliation were obsessional, for he was never aggressive in any other connection. Even the spitting, as he indicated himself, might have been a ritual attempt to cleanse the mouth.

Other psychological evidence of rigidity and obsession formation lay in his flair for clocks and calendars, for mental arithmetic or for knowing the date of next Thursday week. His memory was extraordinarily retentive for detail, but the act of social communication represented by learning to write was beyond him.

Leslie's emotional fixation was at the 4-year-old-level and his rigidity and obsessions were such that he could only progress in an encouraging and supportive atmosphere.

OBSessional REACTION PATTERN

Giles R. (62) 4.2 years

Giles had such tempers that his mother said 'it's as though he's got something in him he's got to get rid of'; and again, 'he's always been a thrower; he also pulls hair, especially mine'. Sometimes he would not eat except in the privacy of the home, and he soiled for a time after grandparents had visited. He was not interested in other children, and his mother complained that he could not concentrate—though he was only 4. His reaction to his brother's birth at 15 months had been so violent that his parents were anxious over a possible third child.

Mr. R. was a university lecturer in mathematics, with a flair for languages and a severe social conscience; a methodical man, but not highly spontaneous. The paternal grandfather's 'nervous breakdown' after the First World War was a source of worry.

Mrs. R. came from a large and healthy family; she was a graduate and an accomplished linguist. She was highly conscientious, even perfectionist as a mother, and there was a strict, religious atmosphere in the home. They lived in a commodious flat with no garden and Giles had a room of his own.

Pregnancy was normal; birth at term, 5½-hour labour; weight 6 lb. 6 oz. He was a contented baby, breast fed 8 months, with mixed feeding from 4 months.

He had bilateral talipes equinovarus, treated by manipulations from 4 months and night splinting from 5 months. He would often scream in the night until the splints were taken off. His mother persevered until 2½, and then again from 3½ and the condition had practically disappeared. From 7 months he had diarrhoea intermittently until 2½, ascribed to 'teething'.

In spite of the above he walked at 13 months and was clean and dry before 15 months, but relapsed when Paul was born; and was not absolutely reliable at 4.

Giles took Paul's birth very ill and had never really accepted him. At 2 months Paul went into hospital with pyloric stenosis and Giles went to a day nursery for about a week, while his mother visited the hospital. She thought 'he seemed to resent this, though he did not show it'. While there he contracted conjunctivitis and a series of bad colds, to which he remained subject.

He could say a few words at 2, and sentences by 4, but he was quite uncommunicative. He attended a local play centre, off and on, from the age of 2.

At 4 years, jealousy of Paul dominated his life. He never allowed Paul to touch his toys, always picked quarrels and left him out of his prayers. Sometimes he would ask his mother to put his splints on Paul. He rarely played with other children, and seemed uninterested in people. He preferred men to women, especially his father with whom he liked to watch engines at the railway station. He had a curious passion for water pipes on houses and always pointed them out to his mother. He was undemonstrative of affection but would be so overcome with rage that 'it is quite sad to see'. In general he was babyish and sucked his fingers.

When he was first at the play centre, his one joy was taking things to pieces, not destructively but inquisitively. He reacted violently when interrupted, but would throw something at or hit the nearest person, not the interrupter. If teased by the group he would hit his small brother, but would retaliate equally violently if his brother was hit by someone else.

He was always extremely methodical and tidy. He had no conversation and would detach himself from his mother when his brother was present too.

Examination

Merrill Palmer Scale: C.A. 4.2; M.A. 3.0; P.R. 5-19 (inferior); σ - 2.0. Giles was compliant and passive, but lacked persistence. Motor control was poor. He could not button; nor move his thumb with a closed fist.

R.S.B. Form L. C.A. 4.2; M.A. 3.4; IQ 80. His response was patchy and poor in items involving social adjustment. There was a hint of ritual formation.

Giles was a small, pale-faced child, who flushed momentarily when hot or excited. He rushed downstairs into the wrong room though repeatedly directed, and grabbed three toys, saying 'take these with you'. When redirected he allowed himself to be dispossessed and immediately became absorbed in other material. Individual movements were slow and repetitive, and three times he asked: 'What's that?' before he was satisfied.

The interview proceeded roughly as follows: 'What's that?' he said three times; and then three times repeated the answer 'Dolly's bed'; and the same with the dolly's bath and taps, also in triplicate. The doctor remarked, 'There is real water in the tap', which he repeated six times in lalling speech. He sat on the floor, muttering to himself, and then repeated loudly for a seventh time, 'Real water in tap'. After a few moments of silent play, he suddenly stood up and said three times, pointing to the dolls' bath, 'Is not any water in tap?' He repeated the answer 'Pretend water in tap' three times.

He muttered, then suddenly said three times, 'Doesn't turn tap on' handing the toy bath to the doctor, 'Please turn tap on', 'I turn tap on'. He then echoed three times, 'Pretend water in tap.'

He showed no echopraxia but he was fascinated by the doctor's gestures and writing, which he asked about. He then filled the dolls' bath with imaginary water, copying the sound suggested by the doctor. Suddenly he stood up pointed to the bath saying loudly three times, 'No plug here'. After a pause, he added very slowly and indistinctly three times, 'Plug must be somewhere'.

Next he picked up a dolls' baby's bottle and said, 'taps screw on', three times (the teat was missing) and added laboriously 'It gone'.

Though his play was little more than fingering the toys, he was generally alert to

the examiner's movements, not shy nor discriminating, and apparently untroubled by being with a strange adult.

It is appropriate to add more about the family and Giles's early life at this point, because the information was gleaned slowly over months. For example, Giles normally got on fairly well with his brother but would suddenly grab his hair or otherwise attack him and would throw things behind cupboards and other inaccessible places. Left by himself, which he preferred, he would fiddle with and manipulate things for hours; he never showed any imagination. His speech was extremely backward and he never used the first person, (though he had used the first person at least once at hospital). He repeated phrases such as 'Daddy can't mend it' over and over for a whole day, intermittently. On the other hand, he had recognized capital letters within a week and noticed that M was an inverted W. When his routine was upset, he would become very temperamental.

A source of difficulty was that Paul was almost up to Giles's development, and physically stronger, though his hand sucking was intense.

Giles walked at 13 months and he was good with his hands at 12 months when he could build and dismantle a tower of 10 bricks. His first words came at about one year, but talking was still poor at 4. Early in his second year Mrs. R. noticed what she termed his 'masturbation': 'he used to bounce up and down on the bed with a flushed face and was obviously enjoying himself'. Somehow, Mrs. R. did not interpret Paul's rocking his cot, sexually. She linked Giles's activity with his obvious preference for his father and worried about the possibility of sexual inversion.

Giles had a curious obsession with things that were broken. Since about 2, he had 'dwelt on macabre things'. Mrs. R. had always felt that he was lacking in capacity to comprehend things and the nature of experiences. His most embarrassing activity was throwing things, he had broken many windows.

Giles had shown little direct jealousy of Paul until 8 months previously when he suddenly left Paul out of the important bedtime prayers and spoke of him 'hatefully'. He also had a bad patch, with dirty pants and screaming for about one month. He had a phase of saying 'I'm Paul'. He expressed aggression indirectly by hiding Paul's possessions, at home he would never strike him, but would sometimes get him down and sit on his head. Giles was very touchy and easily thrown into a storm of rage and panic. His fears were often unaccountable, e.g. sudden terror at a familiar dog. He also pulled other children about in a way that alarmed their mothers.

On the whole, he had not been a cuddly baby, but he had enjoyed being nursed and sung to by his father. Though much was said about difficulties it appeared that Giles, mostly, had been good and compliant; but with little capacity to adapt to changing circumstances and with no control when frustrated.

Comment

Ordinarily one would have considered a baby fortunate in the possession of such warm-hearted, well-adjusted, conscientious and well-educated parents. But this case history might well give an orthopaedic surgeon treating talipes equinovarus, food for thought.

Manipulation, splinting and night-time screaming seem materially to have reduced the mutual pleasure in the mother-child relationship and impaired the

mother's confidence. Even so, Giles's early development was forward and it is possible that his mother pressed him quite hard.

One might enquire why the mother sensed his reaction to the day nursery at 17 months as resentment. The evidence of an adverse reaction is impressive; he contracted conjunctivitis and bad colds, from being forward he became retarded, talking was particularly delayed; he started rocking (interpreted as 'masturbation'); he developed 'an obsession with broken things', and 'dwelt on macabre things'; he seemed unable to understand experiences; he started throwing things, apparently without cause.

It seems that Giles's basic relationship with his mother was impaired by the night-time troubles, but he was somewhat over-compliant to her strict infancy régime. His jealousy of Paul's birth was strong but was not expressed directly. Instead, his obsessional control of his feelings made him both rigid, unadaptable and 'uncomprehending' and liable to inappropriate explosions of aggressiveness. With his father his affective relationships gained strength, and jealousy appeared more directly later.

On the whole Giles was recovering, but it seemed likely that his remoteness, with obsessional overcontrol of feelings, would always make him subject to sudden aggressive impulses. There was also a big problem in his intellectual inadequacy for his own family.

INHIBITION

Barry R. (63) 11.10 years

Barry was referred because of timidity and lack of spirit; trouser wetting; bouts of severe pain thought to be 'imagination'; and 'fainting fits'.

Barry lived with his mother and stepfather-to-be and stepbrother, aged 18 months. Housing was adequate and Barry had a bedroom to himself.

His own father was a railway porter who had left Mrs. R. after 3 years of marriage, when she was 6 months pregnant with Barry.

Mrs. R. was 34 years old. Before the war she had worked as a waitress. She lived with her husband at first in the maternal grandmother's house, but in wartime he joined the R.A.F. and she worked as a bus conductress until 4 months pregnant, and restarted one month after Barry's birth.

Four years ago she had taken Barry to live with another man whom she intended to marry when her divorce became absolute, due in about one month's time. The divorce had been unpleasant, but, at the time of the consultation, she was feeling relaxed and happy for the first time for years.

The mother was distressed during pregnancy by her husband's infidelity and blamed this for the birth being 6 weeks early. Labour 15 hours; birth weight 4 lb. 3 oz. Barry was retained in the premature baby unit for 5 weeks, but the mother left hospital after 3 weeks and returned to the buses a week later. The maternal grandmother cared for Barry during working hours.

Bottle feeding was easy and Barry won a baby show prize at 6 months. Weaning to solids was also easy but he demanded an evening bottle until 18 months. At 18 months Barry could walk, talk a little, and was fully toilet trained.

At 23 months he was 6 weeks in hospital with dysentery, without a visit from his

mother. He 'seemed a different baby' on return home, quiet, subdued, and had 'forgotten how to walk'.

The next two years were uneventful. At 3.10 he was admitted to a general hospital with broncho-pneumonia. He screamed violently when visited, and he became covered with septic spots. His mother transferred him to a children's hospital where he remained for 3 months; and he spent a further month at a convalescent home, where his mother visited weekly. He was sent home because of bedwetting and obvious fretting. He became dry again upon return home.

He was docile at school but, to his mother's disgust, learnt nothing. At 6 his mother established a home of their own. He wetted the bed, which the general practitioner cured at a flat rate of 1d. per dry bed. Instead, Barry wet his trousers by day.

His serious backwardness and discouraged attitude became important at junior school. At 7½ Barry's future stepfather came to live with them. His mother said 'Barry accepted him with his usual stoical lack of feeling', but he chose to stay with his 'father' while the baby was born. At 11, he took reasonably well to a secondary modern school.

Barry was very reserved, never showing his feelings, undemonstrative, and rejecting any caress. His mother thought that he was unnaturally docile, 'too good', for he would do anything he was asked to do, whatever his own feelings, and would never 'answer back'.

He played imaginative games with Dinky toys, and always took his teddy bear to bed. He made no friends, and disliked boys' games and even family walks. He was polite and candid, over-generous with other children, entirely accepting and incurious.

His mother felt that the stepfather had done his best. Barry was 'very sweet with the baby'. He had not been warned of David's coming and had cried bitterly when first told.

Examination

R.S.B. Form L. C.A. 11.10; M.A. 9.6; IQ 80; P.R. 10. Barry lacked confidence and his performance was variable, owing to anxiety. He was particularly low in vocabulary and his reading was slow and inaccurate, more than 2 years retarded.

Barry was soft spoken, a sallow child with heavily lidded eyes. He looked well-scrubbed and wore long trousers. He ignored the toys but, instead, sat bolt upright and quite still, and talked volubly if not informatively. He preferred his new school and liked science best. He could not name his worst subject, but with prompting offered reading. He said that his wetting was worse when he was nervous or excited, and he often did not realize until afterwards. His father worked as a glass loader and his mother worked at home doing 'stickies'. He was unenthusiastic about David, but claimed to have a friend with whom he liked to play cards. Asked about outdoor pursuits he volunteered 'the pictures' and, as an afterthought, football. He offered information about some recent fainting fits, which seemed to be syncopal.

His mother mainly stressed his 'lack of go', his restlessness, boredom and forgetfulness. He always played with much younger children; she spontaneously referred to his hospitalization at 2, with dysentery, when he was left much alone, lying in a cot. 'He quite forgot how to walk and seemed very subdued, in fact he has never been quite the same since.'

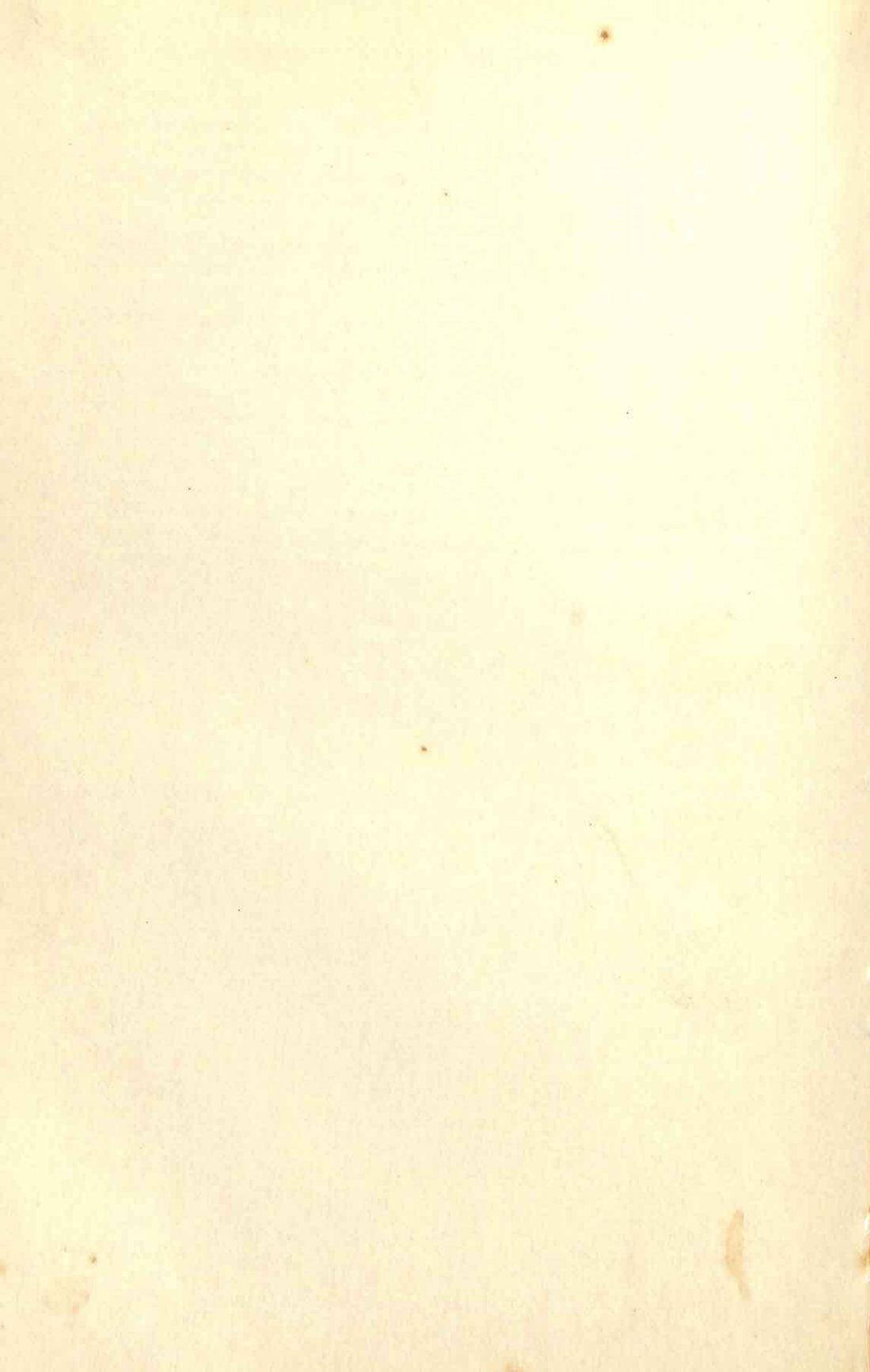
Comment

Barry was inhibited, over-controlled, over-good, and distinctly lacking in masculinity. The main aetiological factors were the lack of a warm supportive maternal relationship, due partly to the mother's unhappiness during pregnancy and her return to work 2 weeks before her premature baby left the hospital, and later care by the grandmother. As often happens with grandmother care, all went well at first, except that a night-time bottle was retained until 18 months. The poverty of Barry's instinct modification was revealed at 23 months when hospitalization caused the collapse of Barry's system of relationships. The grandmother regime pulled things together at a poor level of instinct modification until hospitalization at 4 again showed up the poverty of his relationships. Barry's storm of aggression was beyond his powers of self-control, and it left him seriously inhibited. Lack of masculine influence contributed to his failure of masculine identification. Upon separation from his grandmother his wetting recurred.

On this basis the pattern of inhibition built up. Barry was 'too docile', lacking in energy, 'wouldn't try', etc. In short, this was a disorder of aggressivity, traceable to first-year relationship weakness and consequent poor instinct modification, which became a serious problem under stress, later. It can be seen that Barry's lack of masculinity was of earlier origin than the period of differentiation of sex, which will be discussed further in Chapter 12.

PART V

The Nursery Age



Chapter 12

Orientation in Social Relationships

THE child who has learnt to walk, to find his way in his immediate surroundings, and to make a few simple words into a rudimentary sentence—say, by the age of 2 or 2½ years—has progressed far beyond the early centripetal position of the tiny baby; but the degree of organization of his interpersonal relationships will still be primitive. Such organization is the important development of the next stage of childhood and may occupy much of the period between the ages of 2 and 5 years.

When walking is firmly established and when the focus of psychological development shifts back to interpersonal relationships, in comparison with infancy there will be a big difference in the quality of relationships that are formed. The child's relationships will no longer be exclusive and entirely dependent, but will admit other people and become more positively outgoing. An important factor will be the sexual differentiation of the child, which will become much more distinctive during the period we are now considering. It is difficult to tell the sex of an infant, apart from looking at the sex organs. At 2, play is still a better guide than appearance, but by the age of 4 or 5 there is rarely any difficulty in determining the sex of a child on sight.

The emergence of a well-defined sexual polarity in a child will naturally affect all relationships within the family, a process to which Freud drew the classical analogy of the *Œdipus* and the *Electra* situation. This early period of sex differentiation is also known as 'the first puberty', a term which recognizes that, somatically and psychologically, its significance is essentially sexual.

With normal sexual differentiation and with an assured position within the intimate family circle, the child will be free to engage in wider social relationships. Much, therefore, depends upon the successful sorting out of the system of intrafamilial relationships.

There is another aspect of development during the pre-school period which requires mention, viz. the emergence of creative mental processes and imagination.

FAMILY ORIENTATION

It is helpful to consider the *Œdipus*, like the *Electra* situation, as involving the whole family rather than, as often interpreted in classical psychoanalysis,

as limited to the sexual guilt feeling of the individual. Elaborations of Freud's brilliant adduction of the *Œdipus* tragedy to illuminate the early sexual differentiation of children have obscured the original, and it may be useful to recapitulate some of the main features of the tragedy.

Sophocles' version is a sophisticated and highly moral interpretation of a primitive and common folk legend. For its effect it must have depended upon the Athenian belief in predestination by Fate, a philosophy in which an ultimate immorality was to rebel against Fate. The tragedy of *Œdipus* was predestined by Fate; his exposure by his father, Laius, was an act of submission by the latter to Fate. His subsequent rescue, his upbringing as the heir apparent to the throne of Corinth and his return to Thebes as a visitor were likewise part of his predestined future. When he killed his own father, *Œdipus* did not know that his victim was King of Thebes; and for 15 years he remained unaware of his relationship to the dead man. His behaviour during his dispute with his father had been conventional to any high-born Greek of his time. In driving the Sphinx away from Thebes, *Œdipus* became heroic and reaped the hero's reward—the throne and the hand in marriage of the Queen. It was not until his daughters came to puberty that Fate overtook him through a chain of coincidence, also determined by Fate. But what followed was not merely punishment, and the play contains no evidence that *Œdipus* was judged culpable; but rather, a terrible Fate overtook the entire family. Jocasta his mother—and wife—committed suicide in *Œdipus*'s hearing. He himself submitted to having his eyes put out and to exile, a particularly disgraceful form of death sentence; and his descendants were to die tragically, in due course. *Œdipus* made only one error in the sight of the Athenian audience. When blinded and about to be exiled, he weakened when he heard his daughters' voices and begged to be allowed to take them into exile with him. Creon's reply was unhesitating, and quite intolerable according to modern ideas of human relations, that those whom the Gods have cast down must not beg for favours.

As Rümke¹ has pointed out in a penetrating study, *Œdipus Rex* is a tragedy and not a case-history of a neurosis. Its real lesson for today lies less in illustrating a small boy's difficulties in moving away from an exclusive relationship with his mother; or those of a man with his love for his mother, than in illustrating the power, persistence and universality of the mother-son incest taboo. To wean small boys from their mothers has been a universal preoccupation, to a significantly greater extent than weaning small girls from their fathers. At no known time in history, nor among any known people has mother-son incest been permitted; usually it has been punished with maximum penalties. No other incest taboo has had the same force. Father-daughter incest, though often regarded with no great severity and

¹ Rümke, H. C.: 'Les doubles neurotiques de la souffrance humaine' (1956) *Evolut. psychiat.*, 1, 331-337.

though probably never approved, has been tolerated from time to time in many cultures. Brother-sister incest has, at times, even been approved to the extent of being made a sign of social privilege, as in the case of ancient Egyptian royal families. Other incest taboos appear to have no more than cultural or local significance.

In Great Britain the existence of mother-son incest very rarely comes to light clinically, and then only in circumstances of the greatest possible anguish. Often such information is suspect, as in the case of the delusions of the melancholic. Father-daughter incest, though strictly concealed, does not require anything like the same intensity of circumstances to bring it to light. The apparently slight mark that father-daughter incest may leave on family life is sometimes surprising (see also Chapter 2), and is reminiscent of the fact that the tragedy of Electra did not strike either the ancient Greeks or ourselves with the same intensity of emotion as that of Oedipus. Brother-sister incest, though not commonplace, is not so uncommonly found that it occasions any special surprise. In some societies, brother-sister sexual love may merely be relegated to what is 'not done'.

Every toddler child must go through the process of sorting out his or her relationships within the family. The time comes during his second year when he must begin to resign his unique and exclusive baby position and take his place as one of the family. Father and other familiar adults will come into the picture in their own roles, and not, as hitherto, as extensions of the mother.

We have traced how the baby differentiates the mother from the rest of his environmental experiences and how this enables him to identify his own body and explore his environment. From the middle of the second year the child's environmental exploration will extend to noticing subtle kinds of differences between people. Commonly, the child will be impelled into the new system of relationships by the arrival of a new baby, or by the withdrawal of some of his mother's interest because of her new pregnancy.

We have discussed the child's passage through his first instinct modification experiences by a process of *identification* with the mother. In admitting interference with instinctual patterns by the mother the child, as it were, absorbs some of the mother's personality. In some respects the child is being the mother rather than himself. As this process of *introjection* or *introception* extends, a split begins to appear in the child's behaviour. On the one hand, much that is primitive and related to the satisfaction of impulses will remain; and on the other hand the adult incorporated within the child will begin to determine his behaviour. At first this is little more than conditioning. The appearance of food, or bath-time, or being in the sitting-room, or proximity to the fire or cooking stove will induce in the child appropriate mother-determined conduct. Very quickly the mother's actual presence will no longer be required to induce this behaviour, which will persist at first during short,

then longer, absences of the mother and will be evoked by other adults temporarily occupying the mother's place.

To the unsophisticated parent the child's adult-determined behaviour is being 'good'; and his impulses 'naughty'. In the English culture mothers will start relying on this development as soon as the child walks, and will treat their child accordingly, with a feeling of self justification. Commonly the English overdo matters and expect too much of a child, adopting a moralizing attitude that might better be kept for more important issues.

It needs emphasizing that the part of the parent that is represented in the child by introjection is what the child can appreciate of the parent. What the parent actually *is* or actually *does* matters less, and still less what she would like to be and wishes she had done. The important influence is what the child perceives and how much he understands of the parental behaviour.

In the well-ordered English family it is considered normal to present the child with simple white and black—good and naughty—alternatives. Goodness is associated with making mummy happy and therefore the child, himself, happy. Naughtiness is the reverse. Thus when the child knows he is 'good' he is happy and does not need his mother's actual presence and approval to keep him so. His happiness becomes a reward that is both greater and more lasting than the immediate satisfaction of a stray impulse. Likewise, he does not need his mother's presence, or threats, or punishment to stop him from being naughty. His unhappiness will do that for him.

So is conscience born and it will have both positive and negative ingredients. Positive—from the point of view of character formation—will be the search for the more lasting kind of happiness, that of a sense of oneness with the ideal. Negative will be the discomfort of unhappiness, to which probably will be added the fantasied anticipation of mother's displeasure and punishment. In this way guilt and anxiety will arise; guilt is the more specific feeling of wrongness, of lack of identification with the loved parent figure. Anxiety is more general, being the feeling concomitant of the frustration of instinctual drives, with the addition, now, of the frustration of the newly modified instinctual urge towards identification with the loved parent figure.

We have now to consider the effect of the child's relinquishing of its infantile primacy. Since sexual differences will cause both different pathways and different results, it will be necessary to consider the boy and the girl separately.

THE BOY

Anyone who watches the behaviour of a 2-year-old boy in a normal home can observe his strong natural tendencies to imitate his father and will also see that when he is copying his father more than mere imitation is involved, for temporarily he will *become* his father, in some respects. Identification will take on more and more of a special meaning as the boy develops, and it will be subject to the significant influence of the quality of his parents' love for

each other. A maturely loving mother will find only pleasure in her boy's growing predilection for his father. She will bring him up to be a man like his father, for the sake of his father. In following his bent towards his father the child is repeating the best of his earlier relationship-formation experiences, viz. following his mother's deepest desires, and identifying with what he can perceive of her attitude. As a result, his relationship with his mother will be enhanced and he will also grow more independent and be further on towards maturity. There will be no guilt or anxiety in his affection for either parent; he will have little impulse for jealousy of either parent, because he has the love of both. Such a child will have the best of all worlds.

Unfortunately, a book on child psychiatry must consider what can go wrong. First, the reorganization of relationships under discussion may present to the child in the negative form of someone (i.e. his father) coming between him and his mother. Then what happens will depend upon the outcome of the child's previous instinct modifying experiences. Perhaps his weaning and other training experiences have not adequately enhanced other satisfactions. In Chapters 8 and 11 clinical examples of out-turning and in-turning reactions, of aggressiveness and withdrawal, and of the ubiquitous regression have been discussed. Similar types of reaction can be seen in the resolution of the so-called Oedipus situations; but there are additional factors deriving from the strength of the instinctual and social forces that are involved in the boy's reorganization and development of his relationships.

At first the boy's instinctual forces on the side of the new development in relationships are weak in comparison with the social forces, which are very strong. Though he has a tendency to identify more specifically with his father, his capacity to perceive masculinity will develop only slowly. Masculinity is normally not presented in the home with any great emphasis, which is, perhaps, why there are such other strong social pressures upon the boy to develop masculinity. Family and society join in relentless pressure upon the little boy to become boyish and to prevent his being girlish. Should his mother's attitude oppose this pressure, as it may, difficulties are bound to follow.

Ranged against the reorganization of the boy's relationships are, first, the *status quo ante*; and second, developing contrasexual attraction between mother and son. Like the boy's capacity to appreciate masculinity, contrasexual attraction will be slight at first, but will gain strength rapidly. The *status quo ante* will be a very powerful influence, especially where the mother-child relationship has not been entirely satisfying, where instinct modification has been incomplete, and where the child has fought to retain his satisfactions at a comparatively infantile level.

The key to the situation is the mother. It is she who can help the boy to perceive masculinity in the father and encourage him to identify with it; who can mediate social pressure and, if she is wise, keep the pressure within reasonable proportions; who by her handling of his instinct modifications

will have 'built in' to the existing relationship its own capacity for further modification and growth; and who can control the effects of contrasexual attraction. However, in order to exercise her key function properly, the mother needs the understanding and the confidence of the father.

It has been suggested that the boy may view these new developments in the light of an encroachment by the father upon his preserves. Hitherto he has enjoyed sole rights over his mother, including the enjoyment of her body, for a skilful mother conceals her other obligations from her infant. More and more in the second year the toddler will become aware of other people in relation to his mother and, particularly, his father. He may then fight his father for primacy with his mother—with resulting victory, or defeat, or stalemate. He may identify quickly and strongly with his father and reject his mother. He may reject his father and cling to his infantile relationship with his mother. He may strengthen his identification with his mother, and attempt to develop his relationship with his father through his mother—another form of emotional infantilism which may cause a general lack of masculinization, or more rarely, but worse, a progressive femininization. Lastly and most unfavourable of all, he may withdraw more or less completely from human interpersonal relationships.

Temperamental factors will cause differences, e.g. strong in-turning or out-turning reactions will have their characteristic effects, especially in regard to the degree of inhibition and repression, and of manifest anxiety. Most reactions will be mixed, though one identifiable pattern will probably become predominant. Or, if the pattern remains undifferentiated, family and social counter reactions to the child's behaviour will almost inevitably fix his behaviour pattern in a single pathway.

I. REACTION OF REJECTION

(a) *Conflict with Father*: A boy may angrily fight off his father when the latter appears to infringe his accustomed rights. This may be an ingredient of a normal reaction, satisfactory resolution of which will add to the stability of the subsequent settlement. If the resulting conflict is unresolved, the alignment of forces will naturally vary from family to family. If the mother supports the child—possibly in the notion of protecting the weaker party—the victory may, in appearances, go to the child, but at a cost of endangering his later character development; or the child may be crushed.

Either outcome will cause the child anxiety, from two main sources: first, the child may see himself losing his mother's love, which will be a prime cause of an aggressive reaction on the boy's part, for his mother's love has been his only important reality until then. Second, in the person of his father he is up against the most powerful person in his environment, and as his capacity grows he may well project on to his adversary his own hostile feelings.

The signs of anxiety will be that he will become more demanding, more dependent upon his mother; he may insist upon his mother's exclusive personal attention and reject his father's friendly overtures. Situations he has previously accepted he may refuse with signs of terror. He may refuse to be left alone at night, demand a nightlight, or insist on getting into his parents' bed. Any communication between his parents will tend to anger him, he will throw a temper tantrum at the slightest provocation. His parents may feel ashamed of and defeated by his behaviour, and may react punitively, believing that he is 'just spoilt'. They may fail to understand that above all, he needs his parents' help in order to resolve the situation.

Some Consequences of Victory to the Boy. The little boy may win the battle; but no such victory can be absolute. Even if the father were driven from the home—a not impossible outcome—the paternal component of his mother's relationship with him would still be operating in the home, and in the circumstances, could not be a normal influence. The greatest degree of victory possible to the child would be a settlement imposed and maintained by his force. He would need to be always armed and always on guard. With an increasing capacity to fantasy his father's revenge, his touchy and disagreeable, fearful, jealous and demanding behaviour would inevitably continue until, perhaps, in the exasperation of his parents, the home atmosphere had become seriously inimical.

The boy's pseudo-victory may have even worse results from his abnormal relationship with his father, which would amount to the lack of a normal father figure for the purposes of identification. To this boy masculinity will be a danger, its strength alienated from love; it may appear to him as a tyranny aimed at the frustration of his need fulfilment. To his inflamed fantasy, masculine strength may appear not only to be baneful, but also uncontrollable. He will lose the important lesson to be derived from a loving father in the control and the constructive use of his natural aggressivity.

Fantasying his father's revenge, this boy may come to anticipate many terrors, a process known to psychoanalysis as 'castration anxiety', which essentially is the child's fantasy of the deposed father's revenge. But at a period before genital sexuality is established, the usual meaning of 'castration' is scarcely appropriate here, unless it be supposed that the child of this age conceives of sexual intercourse as the normal consummation of his loving relationship with his mother. Here a less specifically genital sexual interpretation will be given to 'castration anxiety', partly from the consideration that the small boy's penis is an instrument of micturition rather than of love. He may well be familiar with erection of his penis, usually in association with a full bladder, but the amount of the erotic component of this is unknown. Masturbation is often described among children of 3 and 4, but it is very doubtful whether the tiny boy's manipulation of his penis is appropriately to be given the values of adult masturbation. There is no evidence that children

of two have qualities of constructive imagination sufficient to enable them to fantasy the sexual act. Few are witnesses of the so-called primal scene, and moreover, the sensibilities of the British are such that a child exposed to this experience will hear it rather than see it. Parental intercourse as overheard by a child is far more likely to be interpreted as a game, or perhaps a fight, than a physical act of sexual penetration.

It is submitted that the genital sexual nature of a boy's 'castration anxiety' has been greatly exaggerated in psychoanalytical literature. There is, in fact, another type of impotence far more appropriate to the small boy's case, and which father can inflict upon his son by the mere act of picking him up and smothering his movements. Inability to do what he wants to do is a spectre that stalks the toddler, and any action by an adult to decrease the child's ability to do things may augment the child's anxiety, especially if it be done in a hostile or critical spirit. This can be proved by the simple expedient of a comparative stranger picking up and holding firmly a toddler who is having a temper tantrum. The child's panic will probably be greatly increased. Only a parent or trusted friend can treat an angry child in this way and get away with it.

Whether the child's anxiety be specifically genital or not is a point for theoretical discussion; there is no dispute about the effects of the anxiety engendered by conflict with the father upon the small boy's development. If the boy's 'victory' is lasting, the paternal influence in his life will be permanently diminished and the child must somehow manage to control his own aggressivity for himself, with what support he can get from his mother.

Some Consequences of Defeat to the Boy. If the boy should lose the battle, his state may resemble that of a child who wins but who breaks down later under the strain of maintaining the situation. There are four main types of outcome.

(i) *Submission.* Regression will be the main mark of submission—babyish conduct and dependence, particularly upon the father. The outcome will depend upon the parents' joint handling of the situation. Often they will be deceived by the change in the boy's behaviour, for a previously 'difficult', aggressive and violent tempered child may become 'easier', more compliant and 'good'. Parents may congratulate themselves on the new development and perhaps ascribe it to their firmness and discipline. They may not notice his undue babyishness, lack of zest for life and progressive inability to undertake social adventures. His over-dependence upon his father may obscure the issue for them. They can recognize mother dependence easily and will be alarmed by it; they may mistake father dependence for growing masculinity and may approve, because the boy is obedient and gives no trouble.

(ii) *Inhibition.* Inhibition may be overlooked for the same reason, that of a previously difficult child becoming easier. His temper tantrums become less frequent, less intense and he will appear quieter and more com-

posed. Often the inhibitory reaction may represent the return of an old unfavourable reaction to weaning (see Chapter 8). Inhibition results from overcontrol of aggressivity. The child's emotional strains are such that he cannot risk exposure to any situation in which his aggressive feelings may be roused. Consequently he will withdraw from threatening situations and his aggressive reactions become more and more buried. Unfortunately for the child, not only interpersonal aggressiveness will be overlaid in this process, for even socially acceptable forms of aggression, such as the learning of new skills will tend to disappear. The inhibited child may be so unresponsive, tense or rigid that sensitive people will feel quite uncomfortable in his presence. Very often the child will be pale and poker-faced.

Obviously, inhibition will never be complete. In milder cases it will amount to a certain rigidity of response; typically, the child's emotional responses will be hard to arouse but when aroused, difficult for him to control. In more serious cases the parents may complain, paradoxically, that the child is out of control and subject to terrible temper tantrums. This is paradoxical because, in fact, the child's threshold of emotional reactivity is really raised, so that he remains unmoved until the level of stimulus is abnormally high. Parents accustomed to his rigidity are thankful for their peaceful existence, which they regard as normal. There are bound to be stresses, however, which cause reactions so strong that they overcome all inhibitory barriers and will overwhelm the child, who has poor capacity to control his emotions once they have been roused. The resulting temper tantrum will leave him exhausted and badly frightened. His intense fear of the experience will tend to augment the inhibitory process, and so a vicious spiral may form. The parents are apt to be equally frightened, and may punish the child or try repressive measures of control; thus adding to the child's anxiety. A more positive parental reaction would be to help the child to learn how to live with his feelings and how to control and employ constructively his natural aggressiveness.

(iii) *Obsession Formation.* One common way for the inhibiting child to resolve the difficulty for himself is by avoiding the conflict situation and withdrawing from competition for a place in the family sun. He will become noticeably self-contained and unadventurous; he avoids new experiences and is happiest when doing very familiar things in an accustomed way. He may become a slave to habit and routine, finding comfort in a repetitive rhythm of living. Order and method become his talismans. In other words, obsessional characteristics develop. We have already discussed the development of obsessional tendencies through over-control during habit training. Difficulties during social orientation constitute another important route by which the obsessional character pattern develops. As the child's cognitive capacity develops, the actual rhythms of life on which he has become dependent will tend to be replaced by symbolical forms. Items of behaviour tend to narrow

down and remain as mere repetitive symbolical gestures that may acquire magical significance during the phase of magical thinking. (See also Chapter 13.) Thus he may develop a compulsion to perform certain acts, trivial in themselves, or gestures with a more or less obvious significance.

The little boy who will not tread on the cracks between the paving stones, in case the bears get him, is playing normally with magical ideas, which have an almost universal appeal, and which attract many adults throughout life. The obsessional child will develop a morbid exaggeration of this normal tendency, and will suffer from compulsions towards neatness and order, to making grimaces, or exclamations, to touch or avoid objects, or dirt; and to avoid all situations in which he may possibly lose control of his own aggression. Obviously he will become sadly unfitted for normal social life.

(iv) *Ritual*. Anxiety and danger, real and imagined, will naturally add to the child's inclination for magic. Among adults there are very many socially permitted forms of magic: lucky charms and amulets, magical gestures and rituals loosely termed 'superstition', touching wood, or rituals concerning black cats or magpies; and countless others. Obsessional magic has been expressed and elaborated throughout the ages in religious ceremonies, and from ancient soothsaying down to the installation of the new president of the Rotary Club. The anxious child, therefore, will have a great deal of sanction from social custom for magical and symbolical acts, but his margin of freedom is generally narrow. The child who is attempting to control forces that may appear to him to be uncontrollable, may find that his obsessional gestures will add to rather than relieve his difficulties. The actions will then tend to become more symbolical or rudimentary, and more automatic.

In the toddler period the main ritual gesture may be the immediate and seemingly shallow cry in frustration. Later, *tics* will appear. These are repetitive and apparently useless motor actions—grunting, coughing, blinking, face twitching, grimacing, head jerking, compulsive thumb or lip sucking, and so on.

Tics tend to come and go, and also vary in character. Some will have an apparent significance: thus, the blinking tic might symbolize shutting some disturbing recollection out of consciousness. Coughing and other tics connected with breathing might denote over-control in strenuous situations, and so on. Often the actual gestures are quite rudimentary and thoroughly interchangeable.

Other Signs of Disturbance—Thumb Sucking and Nail Biting. Finger, thumb and lip sucking may often come into the category of tic, notwithstanding their obvious auto-erotic component. Nail biting likewise, but the aggressive significance of nail biting is more obvious. It appears to originate in imperfect control and direction of aggressive impulses which, baulked of an external object, become expended upon the subject himself. This solution to the problem of aggressivity has the added effect of punishing the biter through

pain and social obloquy. When the motive for nail biting is the neurotic infliction of self punishment, scolding and punishment will be ineffective cures.

Nail biting often differs from a tic in that, whereas a tic is a symbolical, ritual and repetitive response to a one-time anxiety-creating situation, nail biting will usually signify difficulty in controlling normal aggressivity, and in directing it outwards on to a legitimate object. The child's aggressiveness may have been increased by a conflict situation.

Stammering. Stammering also belongs to a category half related to tics. Talking is something which the individual puts out into the world, and is a form of aggressivity that needs fine control for its proper development. The aggressive significance of talking is very obvious in wordy warfare and in very many folk sayings.

The subject of stammering is too complicated for proper discussion here. Broadly speaking, stammering consists either of a difficulty in initiating speech; or in its control, when initiated. Difficulty in control may involve single words or syllables or, more rarely, whole phrases or sentences. Much of stammering is due to efforts to overcome the block, which will suddenly give way and the words will tumble out, more or less out of control. Some children will snatch at clichés or catch phrases to help them overcome the block, and then out will flood some more or less inappropriate formula, in an unevenly pitched voice. Other children will stumble at sounds of some apperceptive significance; or at emotionally toned ideas. It is characteristic of the inhibited stammerer to be very much worse when he is less at ease.

(b) *Father Dependence:* can be another form of a passive solution to conflict with the father. The child will fail to develop his own individuality and will remain babyish and sexually undifferentiated. The outcome will depend on the parental reaction. If, as often happens, they are foolishly pleased with their little boy's overcompliance and 'goodness', and fail to recognize his babyishness and lack of emotional development, this reaction may be prolonged until after the child reaches school age, with potentially disastrous results.

2. OVER-IDENTIFICATION WITH FATHER

Perhaps the commonest active reaction to the so-called Oedipus situation is that of over-identification with father. In contrast with over-dependence, which tends to leave the boy uncritically dependent on both his parents, accepting their way of life, conservative and unadventurous; in over-identification the accent is upon excessive masculinization, with often a negative component in the form of the devaluation of things feminine. The boy will over-identify with what he perceives of masculinity, as presented in the father-mother relationship. On the one hand, he may erect an idol of femininity, idealized, unapproachable, representing the mother whom the

child worships from a distance through the father. In later life, the boy may dissociate the girls whom he meets from this abstract ideal, with the attendant danger of never being able to synthesize sexuality with love.

On the other hand, the boy may devalue everything feminine, including his mother and remain misogynist up to the age of puberty, when his sexual maturation may precipitate a conflict. In the woman-hating reaction, often the mother will be protected from the boy's hatred by the father's attitude. However, where there is ambivalence or negative feeling between the parents and where the father secures the child's exclusive allegiance, the latter may have nothing but contempt for his mother.

The long-term danger of over-identification with the father is that of prolongation of the normal adolescent phase of homosexuality. The boy will find difficulty in making love relationships with girls. Throughout adolescence he will be strongly masculine and the masculine group pursuits of that period will satisfy him intensely. He may have enormous difficulty in transferring to a heterosexual type of love relationship. Another danger may be of a compromise resolution of the problem, a tendency to fall in love with youths of immature masculinity to whom he himself becomes an object of identification because of his over-masculinization. He may also 'fall' for boyish and unfeminine girls, when bisexuality rather than uncompromising homosexuality would be the likely outcome. He would have no very strong tendencies to attach himself to other individual males, but rather have a general state of predilection for masculinity, coupled with a low valuation of femininity.

3. REGRESSION

Intermediate between the father and the mother-centred conflict situations will come the reaction of general regression. Regression is a universal tendency of children in difficulty, and its chief danger is that it may result in a lasting backwardness of development. The regressed child will go back in his level of behaviour to a period of life in which, in comparison, he was happy. Regression will quite commonly be the child's main reaction to difficulty during the 'oedipal' period, and its main symptom is a jealous clinging to the *status quo ante*. Owing to the strong British social pressure to turn little boys into men, which often causes over-identification with the father to pass unnoticed, regression will commonly be mistaken for excessive girlishness, and may cause undue anxiety for this reason. There is, perhaps, a culture-bound notion which may confuse matters, that it is masculine for a child to behave in a positive, adaptive manner, and feminine not to do so.

4. REACTION OF IDENTIFICATION WITH THE MOTHER

We have discussed the natural tendencies towards maintaining the boy's fixation on his mother, which are opposed by strong environmental pressures.

There are three main streams of mother-identification reaction which, though not clearly separable in origin and symptoms, can have markedly different end products.

(i) *Infantility*. The infantile reaction resembles the passive reaction of over-dependence on the father, with the difference that it is the mother with whom the child will identify. The boy does not even begin to move away from his mother, but will remain immersed in his infantile relationship with her, a state that will largely inhibit his development. He will not reject or avoid his father, in fact he may have a lively relationship with the latter, but only in an infantile egocentric pattern. Such children will commonly be treated like dolls by unwise parents.

(ii) *Lack of Masculinization*. In this common reaction the boy does not remain totally infantile, but develops slowly, closely identified with his mother behind whom he hides. He is 'tied to his mother's apron strings'. He may have quite a strong relationship with his father, but only through his mother; as in the preceding case he will tend to be treated as if he were a toy or plaything and to develop little in the way of masculine identity.

Lack of masculinization may result in permanent mother fixation. The boy may show little spontaneous move towards mating so long as his mother is alive and may put up with his father only for his mother's sake. He will be in his mother's hands; she may select a girl for him; or he may be impelled into marrying a girl because of her real or fancied resemblance to his mother. In either case there may be disaster if he does not come to value his wife for herself; for the real or fancied resemblance to his mother may wear off quickly and leave him feeling that he has been deceived into marrying the wrong type of woman. Another possibility is that the young man (though in his late thirties or forties, he often appears young) may have a delayed adolescent rebellion and hastily marry the antithesis of his mother. The chief danger of this will occur immediately after the mother's death and, since the latter appeared to her son to be the embodiment of stability, trustworthiness and morality, it can be guessed what type of girl he may choose. Sometimes in response to an old mother's worry about what will happen to him, or at a decent interval after her death, the mother fixated son will marry a colourless young woman 20 or 30 years his junior. So he will escape any keen guilt feelings about infidelity because his heart will remain with his mother.

The risk behind the reaction of lack of masculinity is of homosexuality, or at least, of bisexuality. The young man is not definitely masculine in behaviour, tastes or appearance. Other men are inclined to think him 'cissy', if not 'pansy'. He is happy with women, but does not form sexual relationships with them because of his prior attachment to his mother. He may reflect his mother's attitude to his father and to men in general. In adolescence the normal pressure upon him to form social relationships only with his own sex may result in his forming a close tie with a man and adopting a distinctly

feminine role (see also Chapter 15). If accompanied by erotic practices, his homosexual fixation may become established. More often, such men are bisexual, with weak and guilt-ridden heterosexual relationships and less guilty homosexual ties. However, as is usually the case in homosexual relationships, neither party is likely to be sufficiently mature emotionally to sustain any relationship that is other than transient, shallow and changeable.

(iii) *Feminization*. The most serious aberration in this group is the reaction of feminization. Intensity of father conflict coupled with a strong maternal counter-transference may complete the little boy's identification with his mother, to the complete exclusion of his father. He becomes positively girlish. It is an open question whether some constitutional predisposition or endocrine imbalance need be involved, for as the child develops, characteristic masculine features fail to appear. It may be that at puberty feminine qualities of physique and temperament will predominate. The outcome, though uncommon, is too well known to need further discussion here.

THE GIRL

We have already discussed certain qualitative differences in the case of the girl as compared with the boy, in respect of sexual differentiation. It will not imply that these matters are less important in girls if as an economy of space, the girl's situation is discussed here in terms of its difference from that of the boy.

Unlike the boy, the girl is helped to relinquish infantile claims of priority on the mother and to form other emotional ties, by her developing heterosexual mutual attraction with her father and by mild social encouragement. She is hindered by the satisfactions of the *status quo ante* and by her growing homosexual identification with her mother. She has no great motive for conflict with her father, but if conflict arises, it is more easily resolved by love than that of the boy. Whatever may happen she is unlikely to lose her mother's support entirely, because of her developing identification. But the most important difference between the case of the girl and that of the boy is the absence of that imperious and often punishing community pressure to turn into something different, which is characteristic of the boy's position.

I. REACTION OF REJECTION

(a) *Conflict with Father*: The little girl may attempt to fight off her father's approaches and to keep her mother to herself, identifying closely with her mother. Only a minority of fathers will react to this situation jealously. Most will not regard the girl's behaviour as abnormal, for they may be charmed and fascinated by the little girl's determined and precocious femininity which may quite quickly lead the child into a relationship with the father, provided the mother helps. The chances of serious rivalry and conflict starting are quite small.

Chronic conflict with the father may induce in the girl a general inferiority reaction and in this connection much has been written about the phenomenon of 'penis envy'. It cannot be doubted that the penis is an object of particular interest to little girls, and commonly they will play games of pretending to have a penis, to micturate like boys and so on. Some people consider that the absence of visible sex organs is interpreted by the little girl as evidence of castration that has already happened; that the anxiety and guilt arising from such a fantasy will cause the common feelings of inferiority that girls have in relation to boys, and the comparative sexual passivity of the female. The major difficulty in the way of accepting this notion is that, just as in the case of the boy's castration anxiety, it is hard to understand how the child is able to foresee the genital sexual function of the penis.

Where society has a strong positive attitude towards masculinity, where heavy pressure is exerted upon little boys to be manly and little pressure on girls to be womanly, it is not surprising that masculinity and its attributes become objects of envy for some little girls. It seems scarcely necessary to postulate a genital materialization of this envy.

It cannot be doubted that many, if not most, girls feel inferior to boys, but unlike the anxiety and guilt feelings of the latter, those of girls will have little sexual content. This fact will become more evident after puberty when, at the risk of over-simplification, it might be stated that whereas men's sexual behaviour is governed by morality rather than by social pressures, perhaps the converse is more true of women.

(b) *Over-identification With the Mother.* There is one unhealthy situation which is specific to girls and which might be regarded, as it were, as 'psychological parthenogenesis'. Let us take the case of an emotionally immature woman whose marriage was a factor in an unresolved Electra situation, who married for Daddy's sake. Such a woman is girlish, immature; but very feminine, dainty, often whimsical, sometimes 'færic', prudish and almost invariably sexually frigid. Her first baby, conceived out of a sense of filial duty, is a girl. The clinical impression is that the condition will only develop when the first baby is a girl; if the first baby is a boy, the mother will either adjust or turn her boy into a girl.

The physical process of parturition is deeply disturbing to this mother. She is narcissistic and cannot tolerate an invasion of her body. Ironically, her lack of relaxation will probably increase her suffering in childbirth; breast feeding will be distasteful to her, and will almost certainly fail. After the trials of infancy, her major preoccupation will be to bind her child to her, to the exclusion of the father. She will become a slave to the child, and though she may complain vigorously about this, she will effectively bring to nought all attempts to help.

The situation may pass unnoticed until the child is 2 or 3 years old, when it may appear ludicrous. The child will be a little satellite, dressed with loving

care, often as an exquisite doll inseparable from her mother. They live for each other, and though the mother may allow a few trusted female friends to have superficial dealings with her daughter, all men will be fought off. This mother will proclaim by her actions, that she, and she only, has been responsible for her child's begetting and rearing.

The mother's narcissism will bind the daughter to the mother's system of perfection and deny her a life of her own. Unless she gets free, the child will grow up in perpetual feminine immaturity, permanently unfitted for adult sexual responsibilities—a Sleeping Beauty whom no Prince Charming can bring to life with a kiss. She has no basis of contrasexual relationship formation and sexual differentiation upon which to build her adult relationships.

It appears that whereas the conflict reaction may not prove so troublesome in the case of girls as in that of boys, that of over-identification may be equally troublesome or even more so. Over-identification with the mother may have many forms less serious than the above example, but which will tend to emphasize the immature femininity of the child, and to delay or prevent sexual maturation. Such a girl is likely to continue to find her love relationships among her own sex, and there are possibilities of homosexuality ensuing in adult life.

Over-identification with the father is more common and its chief danger is that, because it is so nearly a normal reaction, it may go undetected and unprevented. The little girl is 'all for her father', and her hostility to her mother might be dangerous if her mother were to lose her nerve and react in kind. The child's coquettishness with her father will be noticed and laughed about, but will be kept in check by taboos; and the result of the child's identification with her father may be that some inhibition of femininity will occur and a masculine tendency emerge, so that the girl will become what is known as a 'tomboy'. We have discussed the value that British parents sometimes set on the boyish girl. Sometimes the parents, secretly or openly, will have wished for a son rather than a daughter and will encourage tomboy tendencies. When this happens there will be some danger that the girl will grow up masculine in tastes, interests and dress, and have no 'use for' her own sex or for her sexual role. According to the degree of fixation and intensity of the process, active or passive homosexuality may result; or if as is more usual, she takes part in no overt sexual activity, the girl may still be a serious social misfit.

(c) *Regression*. As with the boy, so with the girl, the commonest reaction to difficulties at this stage is that of regression but, in this case too, social pressure on the girl will be much lighter and her babyishness may pass unnoticed or even be admired, thereby exacerbating the trouble.

SOCIAL RELATIONSHIPS AND SIBLING RIVALRY

The establishment of wider relationships and the differentiation of sex will

enable the child to enter family life, where he may encounter sibling rivalry. If the mother should become pregnant again when her child is between $1\frac{1}{2}$ and $2\frac{1}{2}$ years and has little command of language, the problem will be how to tell him. Once the baby has arrived most mothers can meet the needs of both children but the mother's possible withdrawal of interest during the second half of pregnancy may present an insidious difficulty. The toddler who has become sufficiently perceptive to have some inkling of the existence of family rivalries may react violently to a noticeable withdrawal of maternal interest. If the mother should over-value 'good' behaviour and attempt to repress her child's hostility, perhaps because of the repressions of her own childhood, things may go hardly with them.

As has been discussed in Chapter 3, sibling rivalry often presents particular problems and it is both encouraged and controlled in the English cultural pattern. Many parents with children close together in ages are anxious about it.

The ability to share parents with siblings is a necessary acquisition of the nursery age; it paves the way to the formation of social relationships in the peer group. Up to the age of about 18 months a child will passively watch other children's play—perhaps interfering inadvertently in order to examine some toy or by imitating the actions of others. Often the toddler's only play role in group play will be that of the baby in the game of Mothers and Fathers. From $1\frac{1}{2}$ to about 3 years, in general, children will play intermittently in each other's company, combining for short periods sometimes and competing at others. After 3 years, children's co-operation will become more organized and more conscious; but in an era of small families, many English children will have little or no experience of free social relationships with other children until they go to school.

With good opportunities for mixing, children may have well-established social relationships with peers by the age of 4 and it is remarkable how early social relationships will become institutionalized, as it were, and how each child in a group will assume a characteristic role based on skill and capacity.

A child's ability to enter into social relationships will depend mainly upon the successful resolution of intrafamilial ties. To put a shrinking, clinging, mother-fixated child into a nursery group for the purpose of helping him with social conduct is to take a big risk. Admittedly many out-turning children with an unsatisfying mother relationship will welcome a less intense form of relationship and take happily to collective life, provided the adult in charge supplies their minimum needs for protection. But to put a withdrawing, regressing child into a nursery group is analogous to hurling a non-swimmer into the water in order to teach him to swim and equally demands efficient facilities, rescue if tragedy is to be avoided.

The peculiar position of twins should be noted in passing. Generally twins do not, individually, get a complete and exclusive relationship with their mother. From earliest days allowances have to be made for the other. This

leads often to difficulties in bodily orientation, a sense of incompleteness when alone which, in exceptional cases, may last throughout life.

CREATIVE MENTAL PROCESSES

The child's long period of exploration, perception and concept formation will result, at length, in the emergence of ability to create and control mental imagery. Its primitive beginnings can be seen in the games of peep-bo! of the child of under one year. It is often laughable to see a toddler playing a hiding game, behaving like the ostrich with its head in the sand and then realizing his error. Dreaming will start at about 18 months, but at first will be confused with reality, and commonly will consist of the simple personification of fears.

Imagery, at first confined to the special senses, will widen in scope enormously with the emergence of speech. The imagination of pre-school children is very limited and literal. It is well expressed by the children's stories written for the youngest group. For example, Beatrix Potter's stories depict simple, everyday, familiar situations and they are peopled with the commoner nursery virtues and vices personified as animals. Nothing happens, the stories faithfully mirror everyday, commonplace events, and thrive on repetition.

Around the age of 4, children's imagination becomes less pedestrian, but some years will have to elapse before the magic of the fairy story can come into its own. Pre-school thinking can be well illustrated by a story taken from A. A. Milne's *Winnie the Pooh*. Pooh is a rather greedy, stupid, but entirely lovable little bear, a combination of qualities that is a source of great comfort to children, for it reassures them about the venial sins of the nursery. Having a passion for honey, he decides to raid the wild bees' nest in a tree. In nursery terms this is a greedy and naughty thing to do, but understandable in a bear.

He takes a balloon and, holding on, floats magically up to the level of the nest. It is a wonderful sensation to float in the sky and he happily sings a little song. This is scarcely magic, all children know that balloons float in the sky—be there never so much evidence to the contrary—and wouldn't it be lovely if balloons did exactly as one wanted?

But Pooh had not reckoned with the bees, who came out to attack him. Every child is disconcerted by unforeseen misfortune. He calls for help; Christopher Robin is there, that omnipotent creature, so clever and so kind, who can do everything, no situation is too complex or dangerous for him. He shoots at the balloon with his pop-gun and down floats Pooh to earth, scared but unharmed.

To these children fantasy is more important than fact. These happenings are not magical, but rather the working out of simple wish fulfilments irrespective of hard reality.

Another example is of Piglet—the struggling hanger-on of the party, younger and less capable than the rest—who finds himself after days of rain ‘a Very Small Animal Entirely Surrounded by Water’. He sends out a message in a bottle, and so is rescued by Pooh and Christopher Robin floating in an up-turned umbrella.

In these stories the author has described with genius the peculiar character of pre-school fantasy, its pedestrian anthropomorphic magic, which is no more than the bending of natural laws for the child’s own purposes. These, of course, are only slight samples of the quality of mind processes typical of pre-school children.

GENERAL PROBLEMS OF THE NURSERY AGE

AN ELECTRA SITUATION WITH AN OUT-TURNING AGGRESSIVE REACTION

Myrtle M. (64) 4.9 years

The family doctor wrote: ‘I would be glad of your help with Myrtle—apart from the fact that she gets recurring colds and nasal catarrh, it appears that her mother is having great difficulty in controlling her.’

The mother had an odd, stilted manner. She replied to a letter warning her about the waiting list: ‘Though regrettable and surprising to me, I fully appreciate the position in regard to the rather enormous waiting list. I will, however, arrange to come at very short notice should there be, as you suggest, the chance of a cancellation.’ She then borrowed books on child psychology and felt better able to deal with Myrtle, by keeping calmer herself in the face of difficulties. She offered no information about herself or her husband without being questioned.

When the maternal grandmother had died, 2½ years earlier, Mrs. M. had returned to keep house for her four younger brothers, three of whom were still living with the M. family, who had only two rooms of their own.

Mrs. M. complained of Myrtle’s difficult behaviour, which had come to a head with her refusal to go to her private nursery school. She had been all right during the first term. Upon her return for the next term, she fought and cried, and Mrs. M. gave up after 4 days. Myrtle developed fears of the teachers and could not be persuaded to go, even 3 months later. Mrs. M. felt that Myrtle was emotionally unbalanced. ‘She is not sure of me.’ She would stop to kiss her mother in the street and be very demonstrative, wanting to know whether her mother loved her even if she were naughty.

Myrtle was often aggressive and cheeky with her mother. ‘She is a real terror.’ She fought back if smacked; she was spiteful; she ‘won’t be told’—knew how to do everything. She had a terrific temper, but if Mrs. M. kept calm herself, Myrtle recovered more quickly. Myrtle was very possessive, e.g. Mrs. M. bought her a cat and she would not allow her mother even to talk to it, which Mrs. M. ascribed to love of power rather than love of the animal. She wanted to mother babies and would not let them do anything for themselves. She ignored toys, but carried on interminable conversations with a favourite teddy. She loved playing with water. She always would have the last word. She would not do what the mother told her,

but would obey the clock or a book and would go to bed when the hands moved to 6.30 without a murmur.

Mr. M. was 28. He had expectations of succeeding to the grandfather's successful hairdressing business. The mother said little about him but apparently he was very determined and made a great fuss of Myrtle, and she of him. Myrtle was inclined to climb all over him and not leave him alone. The father was conventionally minded, ambitious for his family. They were always well dressed.

The mother though stilted in manner, was not unfriendly. She had always wanted children, and the marriage was happy. They had avoided further conceptions because of their overcrowding and Mrs. M.'s preoccupation with keeping house for her brothers. They were also beginning to think they could afford properly to educate only one child.

The pregnancy was pleasant, except for the father's absence in the army. Normal labour lasting 20 hours; birth weight $7\frac{1}{2}$ lb. Breast fed 7 months, weaning easy. Mrs. M.'s recollection was of a perfect infancy with no troubles. The father's demobilization made no difference, for he took to the baby. The maternal grandmother died when Myrtle was 2 and their return to look after Myrtle's four uncles meant a great deal of work for Mrs. M. without much domestic help. Myrtle went to a day nursery, but she was not happy there. She cried, said she felt sick, refused dinners and complained of other children's messy ways. Mrs. M. persevered for 11 months before giving up.

At 4.3 years, Myrtle went fairly willingly to a private nursery school for the first term. She justified her refusal to return by saying she was frightened of the teachers. Probably this was less objectively true than an expression of her necessity to find a reason. Mrs. M. was concerned to get a certificate in order to reclaim school fees under an insurance policy.

Myrtle's health was good, except for a running nose. Mrs. M. complained that her psychology books stated that if you did nothing about your child's nose picking, the habit would disappear. She had followed the instructions faithfully, but Myrtle had not. Occasionally Myrtle bit her nails, and very occasionally wet her bed.

Myrtle had a very vivid imagination and imagined rats and mice in her room, according to her mother; but this may have been merely an explanation to justify her terrors. She always made a terrible fuss about accidents, if she cut her finger her mother had to go through a great ritual of bandaging.

The general impression emerged of a very vivacious, active, excitable girl who could not be told about a treat before the time because she made herself almost ill with anticipation. She was sometimes a 'real terror', but very distractible and often 'up in the clouds'.

Examination

Merrill Palmer Scale: C.A. 4.9; M.A. 6.2. The psychologist noted, 'Myrtle was quick and neat with her fingers. She was at first reluctant to leave her mother, but soon became interested in the tasks, and reluctant to finish. She was quite independent, and never asked for assistance. She displayed impatience during the setting out of a test.'

Myrtle was very pretty, clean, well dressed and tidy. Her manner was very hesitant, and at first 'mummyish', but when tempted by toys she allowed her

mother to go. She then proved to be out-turning, friendly and inquisitive. She was distractable, explored and passed a comment on everything, but did not play with anything. She would say, 'I've got a car like this'. She was demanding though friendly and kept her attention on the doctor. She became livelier, more familiar, and made little jokes. She showed a jocular hostility, not amounting to rudeness, but a little pert and cheeky.

Her mother at a following interview confirmed the earlier impression of artificiality. She had remarkably little movement in her facial expression. She said that Myrtle had improved, but after a visit to her paternal grandmother had returned very rude again. She talked in her sleep and was restless. She complained of tummy-ache, pains in her limbs, she picked her nose, could not be bothered with toys, got bored; and was happy only as long as her mother was taking notice of her.

Mrs. M. barred an ordinary infants' school because she was afraid that Myrtle would pick up rude expressions and bad habits. She felt very strongly that Myrtle was not sure of her and this was the reason for her demanding so much reassurance.

Comment

Myrtle's behaviour showed over-dependence and babyishness mixed with hostility and aggressiveness, and anxiety over all.

Mrs. M. was a cool undemonstrative person, apparently incapable of a spontaneous show of affection towards her child. It is possible that the family peace during Myrtle's first 2 years came from a quiet regular routine, with few demands upon the child, and with relationships at a low pitch of psychological tension.

Mrs. M.'s return to the family home after her mother's death suggests a degree of family fixation. Myrtle evidently regarded her placement in a day nursery, at the tender age of 2.5 years, as a banishment, and her mother showed lack of sensitivity in persisting with the nursery for 11 months.

Myrtle's attitude to her mother was a mixture of hostile aggressiveness and of babyishness, demanding affection and reassurance. With her father she was more constantly demanding, with a distinctly cruel streak when she felt more secure.

There was an obvious triangle in this situation, and the mother's coolness made her the odd person out. Myrtle's fight with her mother for primacy with her father had thrown a strain upon the relationships of the three. She had a considerable burden of anxiety from her competition with the most important person in her environment, which showed up in her disturbed sleep, bitten nails and general touchiness.

Two divergent tendencies were apparent in Myrtle. On the one hand, her femininity had been enhanced by her (ambivalent) identification with her mother and the developing contrasexual attraction with her father, which had countered the regression caused by identification with a cold mother. On the other hand, the rough, hectoring attitude she so easily fell into implied an increasing masculinity.

Her anxiety was so little under control that even trivial things hurt. When she went to school at 4.3 years, residual anxiety from her day nursery experience made her adjustment marginal and it broke down under a mild threat by an irritated teacher.

The mother attempted to deal with Myrtle's fears by her own method of over-

control. A warm and reassuring attitude might have resolved the matter, subject to some rough and overbearing behaviour on Myrtle's part.

Subsequently Mrs. M. had great difficulty in accepting the idea of treatment, but Myrtle's continued school refusal forced the issue. During a 6-month treatment period Myrtle became more settled and constructive, after an early disturbed patch.

An interesting development was that this family quarrelled violently with their neighbours and, irrationally, blamed this for Myrtle's difficulties which had, in fact, preceded the quarrel. By this time she had been attending school for some months, and the parents' anxieties being allayed, they wished to discontinue treatment.

Postscript

They returned 5½ years later. Myrtle was very resentful of her younger sister aged 3½. The parents felt that she had derived benefit from the previous attendance and, to put it bluntly, wanted her cured again.

Once again it became evident that Mrs. M. was a rigid, fundamentally uncomprehending person who was not giving Myrtle the security she needed. Mrs. M. really could not tolerate Myrtle's attendance, and treatment was not worth perseverance.

AN ŒDIPUS SITUATION WITH A FEMININE-TYPE REACTION

Roy L. (65) 14 years

The family doctor wrote: 'Roy tends to burst into tears for very little reason and has difficulty in getting on with other boys at his technical school.'

His mother, comfortable-looking and outsized, added that Roy also complained much of aches and pains in the head and limbs. At 8 years he had been examined at hospital because he 'kept dropping things, cups and so on'.

Roy's dockland family consisted of mother and father and 9 children. One year previously, with only the three youngest children still at home, they had removed from their four dingy East End rooms to a new 5-roomed flat on an enormous housing estate. Mrs. L., given a Hoover and a television set by her children, was so bored with life that she could scarcely contain herself. Father, aged 56, was a heavy goods driver on shift work. He had been a good husband and father and these parents together had brought up successfully a very large family on a very small income. He was deaf and inclined to be irritated by Roy's 'cissyness'. Mother, aged 56, was a motherly, warm-hearted person, enormously proud of her family, but worried that Roy was so different from the others. She suffered from hypertension.

Siblings:

1. Baby, died in infancy.
2. } Twins, still-born.
3. }
4. Mary, 36, married, 2 children, living away.
5. Baby girl, died at 11 months from accidental burns.
6. George, 32, married, 2 children, living away.
7. Johnny, 29, badly wounded in the war, married, living in Belgium.
8. Tony, 27, recently married, living away.
9. Teddy, died at 11/12 after measles.
10. Lenny, 23, married, living away.

11. Kenny, 20, in Navy, signed on for 12 years.
12. Doreen, 18, shorthand typist, living at home.
13. Roy, 14, technical schoolboy.
14. Barbara, 13, schoolgirl, 'real harum scarum'; a tall attractive girl, who competed with Roy. Five had attended grammar school.

When Roy was born, seven other children ranging from 21 to 3½ were living in their 4 rooms on the third floor. Mrs. L. used to drag the pram up and down three flights of stairs, with the two youngest children in it. She was admitted to hospital with hypertension for the last 6 weeks of pregnancy. Confinement was easy and the baby healthy; breast fed for 9 months. Roy was a 'good baby and cried very little'.

The mother's next conception passed unnoticed for 6 months, due to fat and irregular menstrual periods, until hypertension caused her admission to hospital when Roy was 15 months old. The three youngest children, 7, 5, and 1½, were in a children's home for 3 months, but there was no information available of any effects of this.

After 3 months at home, Roy was evacuated with his mother and the baby, for 6 weeks. They returned home for a few weeks and then went away again for 18 months.

Roy lived at home again from 4 until 6, and then was evacuated with Doreen and Kenny for one year. One of his several foster homes was rather severe. While away, he broke his arm above the elbow and it was 'badly set and has left his arm deformed'. He was so self conscious that he would never wear a short-sleeved shirt.

Mrs. L.'s description of Roy is worth giving practically verbatim: 'He won't go in for sports, in case he gets hurt; he spends his time reading, so he don't give vent to his energies . . . he's very good with his hands and has a wonderful headpiece. He talks so much at home that his sisters get fed up. . . . He has always been jealous of Barbara, I daren't buy her any new clothes without getting him some little present. He hasn't got any real friends, and seems to prefer being alone. . . . He is very thin, though he takes his food well . . . sleeps well but talks in his sleep. He's very clean in his ways, washes himself careful especially after going to the lavatory. . . . He gets moody and depressed at times and bites his nails badly. Other times he goes round singing. He's a kind, thoughtful and loving boy, very free-hearted and generous. He likes to help people and adults always take to him.'

The whole family, including Roy, was ashamed of his bursting into tears when he was angry or embarrassed.

Roy liked his technical school but mixed poorly in the playground. He gave no trouble, worked hard and got satisfactory, if not brilliant, results.

Examination

R.S.B. Form L. C.A. 14.8; M.A. 16.6; IQ 117. He co-operated and was attentive but did not exert much effort.

Roy was an undersized boy with well-kept yellow hair and a pink-and-white complexion. He looked extremely neat and clean, his manner was brisk and his smile friendly. He appeared anxious to talk about his difficulties. He thought the other boys were too 'cocky'. He showed considerable feeling in talking about his habit of bursting into tears whenever he got angry or annoyed. He could not control himself. He claimed not to mind boisterous play, but could not stand fighting

nor stick up for himself. He would burst into tears if his father shouted at him. He would much like to be bigger and heavier, and he felt self-conscious about his broken arm. He spoke enviously of Kenny's greater fitness. His only reference to Barbara was 'I don't like her, she is always getting me into trouble. She is bigger than I am.'

He would like to become a motor engineer, but his only hobbies were reading adventure books and watching television. He enjoyed helping his father and mother in the house.

His mother, interviewed immediately after, emphasized Roy's worries and fears, especially his fear of her getting hurt. He was a very good and willing boy at home.

In reply to an enquiry whether Roy made friends with older boys or men, Mrs. L. immediately described an incident when Roy was at the cinema with her. A man in the row behind spoke to Roy and followed him to the w.c. where, according to Roy's story extracted by questioning, he exposed himself and wanted Roy to masturbate him. Roy was frightened and ran back into the cinema, and the man disappeared. Mrs. L. took no action because she knew that this would be futile and she thought that Roy had not been greatly upset.

Comment

Roy's lack of masculinity was in sharp contrast to the social robustness of his strong dockland clan family. Family relations were rather impersonal, for there were too many children for strong identifications to form between the younger children and their parents. The father was deaf and elderly, and the mother had been harassed by many children in cramped quarters. In such a family adjacent siblings are vital to a child's emotional development. Roy had Doreen, 3½ years older and therefore rather remote; and Barbara only 18 months younger and therefore close on his heels and, in addition, she was the youngest and an attractive little girl. Her undue share of family attention was greatly to Roy's disadvantage.

What were the effects of his disturbed history? At 15 months he was separated from his mother for 3 months, and it is not likely that at that age he could form satisfactory substitute relationships with his 7- and 5-year-old siblings. When he returned home a new baby had possession of his mother. This could have resolved itself in a dockland clan, had family solidarity been maintained, but unfortunately two separate periods of evacuation with his mother and the baby practically cut him off from his father and siblings.

Therefore on top of his disturbed infancy he was at the same time deprived of male influence and made to compete for his mother. Roy perforce identified with his mother, appears to have regressed and to have shown only weak development of masculinity.

At the age of 6 when still considerably fixated at an oedipal stage, he was evacuated again with Kenny and Doreen, now aged 12 and 10 respectively. One of the foster homes was 'rather severe'. Roy broke his arm, with a bad cosmetic result. Upon his return home a year later his regression seems to have been intensified.

Roy's lack of masculinity was only too obvious. He was not particularly feminine, but was a misfit in male society. He could not stand up for himself and was seriously inhibited, being over-good and obsessional. Most important, he was regressed and babyish, tears were always only just round the corner.

Mrs. L. was worried lest Roy was a potential homosexual and evidently the man in the cinema had responded to Roy's lack of masculine differentiation. However, the opinion that Roy's condition was lack of masculinity rather than feminine tendencies was borne out by his response to psychotherapy which, backed up by his healthy family atmosphere, resulted in a quite remarkable improvement.

AN OEDIPUS SITUATION IN A NEUROTIC FAMILY ATMOSPHERE

Ian P. (66) 9 years

The school medical officer wrote: 'He is causing considerable anxiety to his parents on account of his habit of twitching and fidgeting and also by reason of his disobedience. He is very irritable and inclined to show temper at the slightest provocation. . . . He is physically sound.'

His junior school headmistress reported: 'He twitches and fidgets and cannot sit still in school. He is in the A group, and not backward in any subject. He is artistic and very imaginative. His conduct is fair; he is inclined to tell tales and be spiteful to other children, occasionally punches and kicks them. His mother is very interested in his progress, but I think she fusses him, and perhaps expects too much from him.'

Mrs. P.'s own complaints about Ian were of his twitching movements, fidgeting and twisting his hands, especially when talking to his father. She made light of his alleged disobedience, he was only occasionally cheeky. Bedwetting, not previously mentioned, occurred about two nights a week. She thought he was babyish but was growing more responsible. She thought that Ian's difficulties related to a nearby bomb explosion when he was $3\frac{1}{2}$, when a trap-door fell out of the ceiling. Ian was so frightened that he refused to enter the room until the trap-door was replaced. Enuresis started at that time and Ian had sometimes walked in his sleep. Ian seemed more nervous since his maternal grandfather's death about a year previously.

The father's parents were separated and he grew up in an institution. He joined the army at 14 as a Band Boy and eventually became a Drum Major. He served 22 years until his discharge 2 years previously on account of psychoneurosis. He had had little feminine society until he married in 1940 when he was 28, under the shadow of overseas service.

The mother was the youngest of a long family, much attached to her own mother. She described herself as 'the baby of the family' and as having been spoilt and a tomboy as a child. She wondered whether Ian took after her, though anyone less like a tomboy than she was would be hard to imagine. The family belonged to the Salvation Army, for which she had continued to work until recent years. After marriage she had remained in close contact with her own mother until 2 years previously, when they got their own flat. Mrs. P.'s general grasp of fact can be judged from her statement that Ian was born in 1941, when his father was away fighting in Germany.

Ian was a wanted child, lest anything should happen to the father while he was serving abroad. Recently the marriage had been under strain because of the father's generally unsettled condition. Mrs. P. was terrified of another pregnancy, partly because of chronic venous thrombosis of the legs after Ian's birth.

The pregnancy was uneventful except for Mrs. P.'s fear of air raids in Mr. P.'s absence. Because of old maternal rickets, Ian and Brenda, aged 8 months, were born by Caesarean section. There were no complications with Ian, who did well.

Mrs. P. wondered whether the fears of bombing that she restrained for Ian's sake were 'coming out' in him. She suggested that it might have been better had she been 'hysterical like other women'.

Breast feeding until 9 months, gradual weaning from 6 months straight to cup and spoon; teething from 6 months. She said that he walked and talked at 9 months.

The mother was fussy about toilet training and claimed that he was clean and dry early, with no difficulties. After the flying bomb incident at $3\frac{1}{2}$ he started wetting again. He had been well until 2 years ago when the family doctor advised as much rest as possible. Since then he had been often at home as long as a week at a time in order to be given a rest.

Mrs. P. said that Ian had no friends. He had learnt to play a violinda (a violin-like contraption with fixed finger spaces), but he would never say whether he was interested in learning music or not. He enjoyed drawing, but always settled down to school work and sums as soon as he came home; whereat his father complained that he was over-taxing his brain. His mother thought it was all right if he was enjoying himself. Ian always dashed at everything, he gobbled his meals. Mrs. P. would tell him to take things quietly but it never made any difference. Mrs. P. was worried about his sleeping, he went to bed at 7 p.m. but did not sleep until 10 p.m. and woke at 5 a.m.

Ian had a facial twitch and at times 'will just sit and stare at his father'. He never talked with his father and seemed frightened of him, which Mrs. P. explained by his early life with his grandparents as the only child in the house. She complained of his babyishness and cheekiness, especially while she was pregnant. As an example she cited one occasion when she asked him to fetch something, and he said 'Getting lazy are we?' The father said she must stop that sort of thing in case it got worse.

Ian had been sent on holiday with the maternal grandmother until after Brenda's birth. His behaviour was impossible while there, too, and spoilt his grandmother's holiday. He threatened to murder the baby, he would play about recklessly on a 'dangerous cliff' and make the old lady anxious. However, when he came home he took to the baby and showed no hostility at all. Mrs. P. kept him at home for a week to help, and said that he could not do enough for her and Brenda, fetching and carrying.

Examination

R.S.B. Form L. IQ 105; P.R. 62.5; Kohs' Block (unfinished) M.A. 9.4. The scatter was normal; vocabulary slightly above his M.A. level. Reading age 10 years. He failed the arithmetic test at Year 9. His tenseness may have interfered with concentration; he screwed a piece of paper and twisted his fingers and made no spontaneous remarks.

Ian was very clean and tidily dressed. He came readily, with quiet and restrained movements, he was very far from dashing at everything. He was pale, large-eyed, with a fragile appearance, carefully groomed with his oiled hair brushed back. He was beautiful in a girlish way.

He seemed timid but eventually huddled over the toys and built a model village on the floor, arranging animals and houses round the church. He introduced a slightly hostile element in a band of Red Indians who shot at the encampment, but he did not develop that situation. He played out time driving the cattle around, with

a fair amount of movement. Ian spoke in a very small voice and said nothing of significance.

In spite of his reputation, no tics were visible and when he was absorbed in activities—of his own choosing at least—there was no sign of fidgeting, either.

Mrs. P. looked much more than her 37 years; she seemed pleasant but rather rigid. Her main fear was of St. Vitus Dance but she had noticed that when he was less fidgety he was more cheeky. He had been less babyish since the baby had come but she wondered if he was frightened of his father, whom he had not seen until he was 4 years old. He had had only about 3 wet beds during the preceding fortnight. She contradicted herself at this point by saying that Ian had never had any baby ways. He was clean and tidy at home and would wash without being told. He was quarrelsome with children outside. Mrs. P. said that they were unsociable, themselves. 'The people downstairs are not my type. I don't like the way they are living.' She had been shocked to discover that this couple were unmarried and living in 2 rooms as man and wife, and that they and the woman's son of 16 and daughter of 14, were all sharing 1 bedroom.

The baby was a lovely, chubby child of 8 months, very contented.

During the course of interviews with both parents it emerged that the father, who was a pleasant, fit-looking man was in a very unsettled condition, changing his job approximately every 2 months. Lately he had changed from milk roundsman to emptying garbage cans at a hospital. He apologized for doing a job unbecoming to a one-time Warrant Officer by saying 'It is a very necessary job'. His pension helped to eke out his earnings. He thought of himself as moody, quiet and reserved. He thought that he still needed psychiatric treatment, but would not have it in the army for fear they kept him in. He felt strange because Ian, unlike the soldiers he was used to, did not jump to obey his commands. He was an unappreciated war hero, who took badly to his wife's reminders that things were unpleasant at home as well as in Burma. He had understood a psychiatrist to say that he had schizophrenia and he was worried because his mother and sister had both suffered from this. The former lived alone and often had violent 'attacks'. The latter had 'queer turns and has had two strokes'. Mr. P. was domesticated and helped in the house, but his wife found him trying to live with. She was irritated by his strictness with Ian, e.g. his insistence that Ian always had a thorough wash, however late at night.

Comment

The parental attitudes and expectations were not helpful. Both parents were immature emotionally. Mr. P., at 14, had exchanged the impersonal atmosphere of an institution for the rigid external framework of army life, with its lack of feminine influence. He did well, but after 22 years' service, and possibly under the strain of the responsibilities of a Warrant Officer, had had a neurotic breakdown.

Mr. P. had had no experience of living in intimacy with another person until his marriage was 5 years old and he had a son of 4. Two years later his military framework crumbled and he adapted badly to civilian life. His concept of human relationships was that of the army barracks and was a poor guide to living with his wife and the children. He understood physical endurance and discipline, but could not take moral responsibility nor Ian's not showing unquestioning obedience.

The mother had been the 'baby' of her own family, it may be surmised that she

had married her husband's uniform; but it is to be doubted whether she perceived the weakness of the man she married, because she was unrealistic about masculinity. Her ludicrous thought that Ian might be taking after her, the tomboy of the family, meant if it meant anything at all, and it would be unsafe to build too much on it, that she had some underlying feeling that Ian was really a girl behaving like a boy. So she dressed him like a girl doll but tried to convince herself that he was a tough specimen.

The circumstances had been so abnormal that this was far from being a real marriage; the child had been intended to be something to remember a dead husband by. A Caesarean section is the epitome of a mother's sacrifice for her child. Mrs. P. blamed all her own troubles on to child-bearing.

Ian had had no genuine father figure, he had only the 'tomboy' in his mother from whom to derive masculinity; it is not surprising that he was very uncertain.

When Ian failed to gain his father's respect he seems to have sought a girlish type of relationship with him. The family doctor did not help, by ordering him to rest and so increasing the nervous atmosphere of pampering. Ian repressed his jealousy of Brenda, and only once dramatically referred to her as a 'stink-pot', to the scarification of his mother.

Ian responded reasonably well to prolonged psychotherapy.

AN OEDIPUS SITUATION WITH ANXIETY AND INHIBITION

Gerald D. (67) 7.10 years

Gerald's presenting symptoms were nervousness, difficulty in getting to sleep, fears, twitches and deterioration in school work.

Gerald had been perfectly good and always top of his infants' school class, and he never lost a mark. At the junior school he was under strong internal pressure, he was reported as nervy and easily upset; and his work had shown a marked deterioration from his own high standard. He had a slight stutter and he was thought to be delicate. The family lived in a small house in an outer London suburb.

Mrs. D. was then aged 42, looked older and dressed rather severely. She proved to be co-operative, sensible and informative and not without humour and insight. Her own childhood was such an important factor determining her attitude to Gerald, that her history will be given in unusual detail.

Mrs. D. was the youngest of seven, born after her father's death. Her own mother had been grossly over-worked and necessarily had had little time with the children. Her eldest brother took over the role of father, but Mrs. D. never felt close to him. Her childhood was marked by worry and insecurity; the family were distributed among the relatives and somebody always seemed to be either coming or going. She was particularly close to her next older brother, John.

She did well at school, and was very attached to the headmaster. The happiest time of her life was at the age of 14 when she went into domestic service with a kindly old man. At 16 she returned home to help her mother look after the three children of her eldest brother and wife who had both been killed in a road accident. Mrs. D. worked part-time as a shop assistant, and this period was one of considerable drudgery and anxiety.

When she married at 22, they deferred having children so that Mrs. D. could

enjoy herself. But her mother died 1 year later, so they took in John, the youngest of her nephews then aged 5. John was a dull, dependent child and had never quite grown up. It was curious that Mrs. D. made no mention of John during the first 3 months of their attendance at hospital. Five years after marriage she miscarried and she resented having no mother to help. She thought that a neighbour's conception after a gap of 9 years was 'bad luck'. Sexual relations embarrassed her and her husband said: 'You are like the North Pole.' Her attitude to child-bearing was both embarrassed and heroic. Referring to her prolapse she remarked: 'Look what children do to you.' Gerald was born 12 years after the marriage.

In spite of all, Mrs. D. had wanted a child and Gerald fulfilled many of her needs. She was fussy and over-protective, always bothering about cardigans and galoshes. She was sensitive about the neighbours' opinion and admitted feeling jealousy of other children playing with Gerald. She remarked: 'I suppose when he is about 20 I shall let him grow up.' She varied between wheedling him and waiting on him; she found it necessary to reason with him interminably and to explain everything. She expected Gerald to be unsociable: 'I don't really like other people myself.'

Mr. D. was a spare, quiet man of 49 with an awkward social manner; he belonged to an old farming family which had lost touch with the land. He had been a clerk in one railway office all his working life. He had visited his parents every Sunday since his marriage.

Mr. D. was solitary and humourless; his only interest was his allotment, where, as his wife remarked: 'He works out his nervousness.' Mr. D. was hypochondriacal, claustrophobic, and had a serious obsessional fear of cancer.

He was affectionate and fussy with Gerald and was usually restrictive and over-anxious. Gerald was never allowed to ride his bicycle in the absence of his father; and if sent on an errand was pursued with confusing instructions and admonitions.

Pregnancy normal; labour difficult; breast fed for 3 months. Mrs. D. had insufficient milk, and it was difficult to find the right bottle formula, until 7 months, when he was gradually weaned to solids. Teething started at 7 months; he walked at 17 months and talked at about 2 years. He was given many enemas as a baby, for constipation.

His mother was proud of her meticulous regularity, especially in toilet training. He became clean early, thanks to considerable training efforts. He was very obedient and good, but gradually developed into a sensitive, lonely child. He remained babyish and was fond of cuddly toys long after the normal age; he avoided other children and became seclusive. His mother dressed him and took off his shoes until he was 7. His only come-back was that he resented being nagged.

At 7, Gerald was in hospital for 6 weeks with mild scarlatina. He was silent for 2 hours when told he was going to hospital, but seemed contented on admission and was much impressed by a naughty boy in the next cubicle. His parents visited twice weekly and the only difficulty was that the hospital tried to insist on a daily bowel action. On leaving, the matron told his mother in Gerald's hearing that for some days he must not be kissed and must use separate utensils. On return home, Gerald talked excitedly about the hospital for 2 or 3 hours, obviously ill at ease, and was much relieved when his mother, divining the cause, gave him a hug. He never mentioned the hospital again but his difficulty in getting to sleep quickly started then; he had to have the door open and the radio on, and called out, sometimes for

2 hours. He fussed about a 'rustling sound' in the wardrobe and wanted his hand held.

Gerald always appeared cold and miserable. He was excitable and sensitive and showed temper if urged on. He could not stand up for himself at school. He preferred playing alone, and when he occasionally played with others he became very excited and 'unmanageable'. He liked one older boy and tolerated a younger one, but had no friends of his own age. Mrs. D. complained that he had 'no social instincts'.

Gerald was excessively reticent and inarticulate; he disliked any show of affection, except with his dolls, particularly a sailor-man named Jolly that he still took to bed with him. The other children used to call him a miser because he saved his pennies. When his mother was ill he was 'very grumpy'. He was sensitive if spoken to crossly, but was physically brave and never cried if hurt. Mrs. D. remarked that he was scared stiff of not being a he-man, but was so sensitive about his appearance that he would not wear a bathing suit.

He was absent-minded and often preoccupied; his mother said 'He does not really live in X—, his mind is miles away'. He built himself a hide-out in the garden, where he spent hours alone. Occasionally he was intolerant of his mother's fussiness, e.g. he once kicked her hand when she was taking off his wet shoes.

Gerald continued to be constipated and was secretive about defaecation: 'He is scared if anybody comes.' Lately he had been showing some sexual anxiety. He refused to sit next to girls; once he had been much upset by seeing a bloodstain in his mother's bed. On a recent holiday Gerald was sharing his parents' room, and Mr. D. turned over in bed while asleep and half lay across his wife. Gerald shouted out: 'Don't get on top of Mummy—get off Mummy at once.'

On examination, Gerald was timid, diffident and polite. He behaved more like a bookworm of 10, but talked in a childish, expressionless voice. On a warm spring day he was muffled up with coat, scarf and galoshes. He was highly intelligent: R.S.B. Form L. C.A. 7.10; M.A. 11.1; IQ 141.

Gerald's progress under treatment is discussed at length in Chapter 19; his condition will be better understood by reference there.

Comment

Gerald like Martin (57) (see Chapter 11, pages 241-4) had a good home, well-meaning parents and had had no disasters or unusual separations. He was an only child except for his cousin, 16 years older, who was living in the house.

The family atmosphere was dominated by the parents' own childhood: Mrs. D.'s life of dreary imposition; and Mr. D.'s father-fixation, and shrinking, obsessional character pattern. Hostility had been deeply repressed in Gerald's father's household.

Mr. and Mrs. D. were in most ways well suited to each other. Mrs. D. had looked for a father substitute successively in her brother, her schoolmaster and her first employer. Her bleak childhood had left her with a strong sense of guilt as well as duty. Mr. D. was so far removed from being a father figure that her choice of him may well have been due to self-punishment; but at least, his inadequacy as a husband gave her an opportunity to assume for herself the masculine role which had been so lacking in her life. In the circumstances, to have a miscarriage 5 years after marriage must have added to her guilt and inferiority feelings.

When Gerald was born, the mother was dominant in the family and the father and the cousin were dependants. The atmosphere was anxious and tense; and all feelings of hostility were inhibited. There was remarkably little spontaneity of emotional expression. Neurotic women sometimes get expiation of sexual guilt from the birth of their baby, but in Mrs. D.'s case, the loss of the previous child had made her excessively anxious and over-protective. The slightest sign of independence or self determination in Gerald was met with acute parental anxiety.

Gerald had reacted by identification: 'There was never a sign of disobedience.' Unlike Martin, who became rebellious, Gerald's aggression was deeply inhibited to the extent that it robbed him of self-reliance and initiative. To control hostile feelings, Gerald not only lacked strong masculine identification, he was also undermined by his parents' anxiety at the slightest display of feeling. Thus his aggressiveness became inhibited at source.

Gerald's mother wished to compensate herself by having an especially close relationship with him; all her life she had needed to have a dependant. However, Gerald's inhibition broke down at times, as when he kicked his mother's hand, or his uncontrollable excitement when playing with other children, which was typical of an inhibited child.

His stay in hospital still further undermined his security and the matron's ill-advised remark was more important to him than she could have guessed.

Thus, it had come about that he could not trust himself in any situation requiring aggressiveness, however slight; even in shopping by himself, or using his high intelligence in school. He was too guilty and too anxious to be able to cope with social demands. He could be constructive only in solitude, where things did not go wrong because of human relationships which he could not manage. He was especially inhibited in the expression of affection and emotion, and was much distracted by excessive maternal demands to which he could not respond.

In short, his attitude to life was 'Letting "I dare not" wait upon "I would", like the poor cat i' the adage.'

However, basic home relationships and his personality structure were sound, and his response to treatment was satisfactory.

SPECIFIC REACTIONS AT AN ÆDIPUS LEVEL

TEMPER TANTRUMS

Patrick T. (68) 6½ years

Patrick, after 7 months in the tropics, returned to England suffering from urticaria, iron deficiency anæmia, and partial collapse of a lung, all of which responded to treatment. His behaviour was disturbed, Mrs. T. said that he had always been 'inclined to paddies when frustrated, as a baby little things would set him off'. Only she could control his tantrums, which might last half an hour. Until lately he had refused to be parted from his mother. He had wet his bed nightly until 6 years of age.

Mrs. T., Patrick and Michael were living temporarily with the paternal grandmother. The father was a Colonial Service engineer and had lived at home only during leave periods, except for the ill-fated 7 months when they had been together overseas.

Mrs. T. appeared to mind the separation very little; she was smiling, charming and cheerful, but remarkably cool in her description of Patrick's difficulties, which she made light of. Her emotions were well under control. She said that the father was not happy about Patrick's reserved attitude towards him. He was undemonstrative and inclined to be severe with the children, and had been upset at not getting instant obedience from Patrick when he first saw him at 18 months.

Mrs. T. felt that there had been nothing of note about her pregnancy, confinement, the weaning and Patrick's early development. Mrs. T. and Patrick spent the first 3 months with a sister and then went to her 'in-laws'. She had been lonely and Patrick was 'utterly spoiled'. The father had been with the family for the following periods of Patrick's life: 18-24 months; 30-36 months (covering Michael's birth); 4.6-4.10 years; 5.5-6.2 years (overseas).

Mrs. T. described Patrick as good natured and affectionate, very alert and mechanically minded; able to amuse himself and loving drawing. She described his outbursts unemotionally; angry retaliation and punishment only made matters worse and she reacted with firmness and emotional withdrawal. The tantrums occurred mostly over silly things, like a drink being too hot. He would roar his mother down and stop up his ears. Normally he was undemonstrative, but after a tantrum he needed cuddling. Michael, in contrast, was good natured and easy going. Patrick had shown bad jealousy only since Michael had been walking.

Owing to moves he had attended school for only about one month. He was fidgety there and had had severe tantrums on the first three mornings.

Examination

Patrick objected inactively to leaving his mother and ranged round the room roaring loudly. Twice he asked to go to his mother and roared very loudly when refused. He watched the assembly of a train with interest, stopped crying but when invited to join in, he spat and hit out.

Eventually he joined aggressively in a mock battle between toy animals but his excitement became uncontrollable, and he accidentally hit the doctor on the nose. This distressed Patrick so much that the interview had to be terminated. Mrs. T. dealt with him calmly, but he was inconsolable for several minutes.

Comment

Patrick's problem was how to control his aggressivity. At 18 months Mr. T. had made a severe impact on Patrick, who had had his mother all to himself; and again later, when Michael was born, Patrick's jealousy had been over-controlled, he reacted with sweetness and offers of toys, but later, the brothers quarrelled incessantly.

Patrick was a masculine person who was competitive with his father (and brother) for his mother. The father, being mostly an absentee, the problem was only occasionally acute, as when they attempted to live together abroad. At other times he was disturbed only when separated from his mother. (His misery in hospital caused his referral to the clinic.) His mother's coolness chronically undermined him, because he received no help in managing his excessive aggressive feelings.

He attempted to batter his way through social life; touchy, ungenerous, jealous; bearing a load of anxiety and guilt; automatically and inappropriately raging when

frustrated. Patrick was denied the full use of his intelligence because he would react blindly with rage to an unfamiliar frustration. Moreover, such behaviour alienates people and would certainly land him in sad trouble with his father. On the other hand, Patrick's good adaptation to the neutral emotional atmosphere of school showed that the disturbance was not all-pervading like a 'first-year' difficulty.

This situation proved responsive to counselling. Mrs. T. gained enough insight to be able to deal with her husband's anxieties when he next came home.

'HATEFUL' BEHAVIOUR TO MOTHER

Marcia M. (69) 8.7 years

Marcia was brought to the clinic by her father because, he said, her mother 'would only weep all the time'. Marcia was hateful towards her mother, and constantly complained that her mother did not love her and wanted to be rid of her. For a year she had been miserable and complaining, crying at the least provocation, even telling the neighbours that her parents ill-treated her. She had no control over her temper. She once stole 8/- from her mother. They felt that she was putting Colin up to similar behaviour.

Most of the difficulties disappeared while the father was home, but unfortunately he was often away.

Mr. M. was alert and kindly. He had used his wartime army connection in the Ordnance Corps to work himself up to a building manager, entirely without trade qualifications.

The mother, aged 35, was the eldest of 5 and had always been anxious to preserve the peace, at any price. She had a 'nervous breakdown' over choosing a husband against her parents' wishes. She had stood up extremely badly to wartime life without her husband, and had become increasingly anxious as their financial and social position had improved since. Her father's death 6 months previously had upset her excessively.

Colin, 4½, and Kaye, 1½ presented no problems.

Pregnancy and birth were normal but Mrs. M. lost her milk. Marcia was a cross baby, no food suited her, she cried much and Mrs. M. claimed that she did not get an undisturbed night for 4 years. Marcia was very thin, finicky over food and was always constipated.

At 2 years poliomyelitis was suspected, her legs were splinted at night and later she wore specially built-up shoes (?talipes).

During Marcia's babyhood, Mr. M. came home only for a week's leave four times a year. When Marcia was nearly 4, Colin was born and Mr. M. was posted overseas. Marcia remained at a residential nursery for 9 weeks because of her mother's illness. She was very unhappy, fretted for the whole 18 months of her father's absence and had great sleeping difficulties.

Her mother thought her dominating and bossy with other children; 'after being reprimanded she cries crocodile tears, hangs her head and then when her father's back is turned a sneer spreads from ear to ear.' Alone with an adult and especially her father 'you could not wish for a nicer child, she's happy and talks sensibly'. With her mother she was obstinate, self-willed and disparaging, but she was extremely nervous, afraid of the dark, and very imaginative. She bit her nails and had sucked a dummy up to about 4 years.

She made poor progress at school until given a man teacher, whom she became 'crazy about and who taught her more in a few months than in the previous few years'.

Examination

Her interest was fitful and her persistence poor. R.S.B. Form L. C.A. 8.7; M.A. 7.4; IQ 85.

Little was learnt from the first examination, other than of her large measure of unresolved hostility. She fiddled with a jigsaw puzzle without making the least impression on it; she appeared to be using it as a defence against the interview. She gave the impression of being friendly, though quiet and self-contained, defensive and unrevealing about things at home. She preferred her baby sister to her brother, because the latter would take things away from the former. She became involved in a long and complicated anecdote about her father waking her in the morning and tickling her, which wasn't fair, and so on.

Subsequently, during treatment, Marcia revealed her inability to manage her hostility, becoming pert and rude as soon as the ice was broken. Her establishment of more stable relationships was impeded by family misfortunes. Mr. M. lost his job, which augmented Mrs. M.'s anxiety. Then he was accused of sexually assaulting his neighbour's 11-year-old daughter under palpably absurd circumstances; but unfortunately he had been consulting his doctor about his impotence, so that the impact of the accusation was very severe.

Comment

Mrs. M. was excessively anxious and dependent, less able than most women to support family life with her husband away. Marcia's early babyhood was unsatisfactory for both mother and daughter, and the former was anxious and increasingly dependent.

The orthopaedic manipulation, which the mother imagined had been on account of poliomyelitis, both exacerbated Mrs. M.'s anxiety and frustrated Marcia. The child made ineffective attempts to compensate herself, but her relationship with her father, in spite of intermittent contact, was a good one.

At 4, in an unusually unfortunate combination of circumstances, Marcia went to a residential nursery and her father was posted away; and she reacted by hostility to her mother. When Mr. M. returned, Marcia's feelings were split: she was happy with her father; but hostile, suspicious and dissatisfied with her mother. In fact she was in competition with her mother for her father, and subject to the anxieties of that state.

The mother was so upset and so uncertain that Marcia became 'out of control'—both out of her own control and of that of her mother. The father was torn between his identification with his wife and his knowledge that he could 'handle' Marcia.

JEALOUSY

Rita H. (70) 7.2 years

According to her mother, Rita upset the household, they could not keep servants, she delighted in getting Nicholas (4.10) into trouble. She had rages, was over-emotional, had nightmares and sleeping difficulties. These disturbances dated from

18 months, when Rita had eaten deadly nightshade berries (belladonna) and was rushed to hospital. Though previously a chubby, contented child, Rita had become pale, thin and disagreeable.

The family lived in a country villa, in modest comfort. The father was 57, a civil engineer by profession, and was said to adore the children but to have little to do with them.

The mother was 47. She had married at 24 but lost her first baby at 6 weeks after many transfusions. She was advised not to have children. The maternal grandparents had been separated for some years when Mrs. H. was adolescent. Her father to whom she was very attached died when she was 36, and she only rarely met her mother. She had had an obscure 'nervous breakdown' at 33.

When she was 39, she took the well-meant advice of a friendly doctor to have a child 'in order to keep the marriage together', but the marriage relationship had not improved.

Mrs. H. had had a hysterectomy at 46 and was away from home for 5 months. She also suffered from thromboangitis obliterans and 'practically lived on phenobarbitone'.

Much sickness early in pregnancy, and sleeping difficulties; she spent the last month in bed. Quick, easy confinement; bottle fed, no difficulty. Mrs. H. varied her account of the start of the trouble and blamed the introduction of solid food at 6 months. She said that the next 3 years were 'awful'; they had eternal battles over food. Toilet training started from birth, but at 6 months, 'she began to teethe and her habits broke down', and there was a prolonged struggle.

In giving a minute account of Rita's personality, Mrs. H. was expansive about her jealousy of Nicholas. Mrs. H. had been delighted when Nicholas, at 3, had fought back to gain an ascendancy over Rita, who was a 'bully and she uses her superior cunning to dominate him, though he admires and loves her'. Rita was unable to enjoy anything, but worried the whole time about when it would finish.

She must always be the centre, demanded to know what was being talked about, eternally afraid of missing something. Mrs. H. said she was a 'know all', an 'exhibitionist' and 'getting much more stupid in the practical things of life'.

Rita's sleep was disturbed and subject to nightmares. She was afraid of the dark. Mrs. H. constantly found and worried about damp patches on the sheets.

She was not liked at school, because her only idea of playing was to bully the others. She had boarded during her mother's absence in the previous year and had disliked it, being terrified by ghost stories told in the dormitory. Lately she had been upset by mention of boarding school.

Examination

R.S.B. Form L. C.A. 7.2; M.A. 9.0; IQ 127; P.R. 95. Verbal absurdities and sentence comprehension at year XI; Vocabulary, Year VIII. Seguin Formboard M.A. 8/9 years. Schonell Graded Word Reading Test R.A. 8.6 years. She showed slight perseveration, probably due to anxiety.

Rita was a small, thin, pale, tidily dressed girl, rather cool and detached, but voluble about emotionally neutral subjects. She complained that she got bored at school. Her ambition was to become a ballet dancer.

She talked about her playthings at home, but only mentioned her parents to say

that her father always gave her a present on his return home after an absence. She complained about Nick's spoiling her toys, though she liked playing with his. 'We have awful quarrels. Nick is very strong; oh yes, he pulls my hair terribly hard.' She would like a baby sister 'but I don't want to have any more boys'.

Mrs. H. said that Rita had been much better on holiday, but had slipped back since, lost weight, and her behaviour and her bowels had both become 'very difficult'. During the last 3 years, three resident domestics had left because of Rita, 'I've seen it happen every time—at first they like her but they soon loathe her. All women make a fuss of the boy.'

She was concerned at Rita's unhappiness: 'I can see her brain churning, she retreats into a world of her own, she must have some private worry of her own.' Nicholas was the opposite, lively and active, though 'very childish—he's rather like a sloppy spaniel'. Rita was a disrupting influence at home, 'she had better go to boarding school soon, it's got to come in any case, she meets so few children at home'.

When a paediatrician had advised tolerance of poor table manners and bad behaviour, Mrs. H. commented: 'It's no good telling me to do that sort of thing; I'm just not that sort of person and I can't do it.'

On the other hand she described Rita as 'pernicketty', 'prissy' and a 'little old maid', who would fuss if the spoons and table linen were not immaculate.

Mrs. H. added to family discontent by refusing to replace a very precious dog when it died. 'Dogs always have worms and fleas and these are bad for children.'

Comment

Mrs. H.'s dislike of Rita was amply revealed in her words and deeds, and it was not surprising that Rita was anxious and unconfident. The key was in Mrs. H.'s own relationships. Her parents had been discordant and her own marriage lacked warmth. Loss of her baby, followed by 16 years of birth control, had unfitted her for parenthood. To have a child for the sake of the marriage had resulted in her rigid, dominating attitude. Rita acted out strongly, and somehow had acquired a reasonably sound basic relationship that enabled her to express hostility forcibly, but not to control it.

Mrs. H. decried her husband's part in family life, but this may have been due to her jealousy of an unresolved Electra situation. Rita's behaviour might have resulted from her ambivalence as seen through the eyes of, and provoked and exaggerated by her mother.

Subsequent events bore out this interpretation. Three attempts were made to start psychological treatment, but Mrs. H. found some impeccable reason for not coming each time. Finally the family doctor wrote that although Mrs. H. wanted to co-operate and was most appreciative of the clinic's efforts, she could not find anyone to look after Nicholas during visits, and had had regretfully to abandon the idea. She could not accept help.

A FRIGHTENED, INHIBITED REACTION

Audrey G. (71) 6 years

Every night for 3 years, about 1 hour after bedtime (6.30 p.m.), Audrey had awakened screaming, often shouting: 'Don't, don't, don't do it.' Sleep-walking

was frequent. She was always tired, lacking energy, day dreaming and lackadaisical.

The mother, father, Audrey and Alan ($3\frac{1}{2}$) lived in a 2-roomed flat, the parents slept on a divan in the living-room/kitchen. The father was 35, a self-employed upholsterer, who was practically illiterate but a good craftsman. He was described as a good father, affectionate, but strict and fussy. The mother was the same age, had been the youngest of seven and had been 'brought up rough'. She described herself as 'the world's worst worrier', but drove herself to take responsibility. She had an overwhelming concern about behaviour and social acceptance.

Alan at $3\frac{1}{2}$ was healthy and no trouble; the maternal grandmother looked after him by day. The family atmosphere seemed united and happy, though very restrictive. An occasionally drunken and rather despised paternal grandfather was the only shadow.

Mr. G. was posted abroad on war service early in the pregnancy, which was an uncomfortable time for Mrs. G. who was living with her own parents. Labour 36 hours, forceps delivery, birth weight 8 lb. 15 oz. Breast feeding supplemented, continued for 6 months; Audrey was a hungry baby, but weaning was easy. With rigid toilet training from birth Audrey was 'spotlessly clean' by 10 months but was still being potted at 8.30 p.m. at 6 years. By 10 months, also, she was said to have walked and talked. She had been a happy child, much petted by adults but lacking child company.

Audrey rejected her father upon his return when she was nearly 2, but at the time that she began to accept him, several months later, her night terrors first appeared.

At $4\frac{1}{2}$ she had 10 days in hospital for the correction of a squint. She said 'What have I done wrong to be here?' but had been controlled and 'very good'.

Mrs. G. in a rare insightful remark, said: 'Audrey has an extra-anxious-to-please manner.' She worried about her mother's health and tried to do little things to please. She had no friends but could amuse herself.

For social rather than religious reasons, Audrey had recently started at a small Roman Catholic convent day school. Audrey found the boys rather rough and for the first fortnight wet her bed, about which her mother was very severe. Mrs. G. complained that the school dinner was inadequate and cold, and she would not let Audrey do any homework, she thought her too young (under 6 years). Whenever Audrey was ill, she was frightened to return to school without a note, anticipating punishment. One day Audrey came home very upset and after much questioning, admitted to having been caned. When Mrs. G. complained indignantly, the Reverend Mother Superior explained that Audrey would not try to listen or concentrate and that she was not making progress in reading or writing.

Examination

R.S.B. Form L. C.A. 5.11; M.A. 6.8; IQ 116; P.R. 83.5. Audrey was tense and excitable, and full of excuses for anticipated failure. She had a good vocabulary. She appeared over-anxious, self-critical, and prone to fail through fear of being wrong.

Audrey was very pale, much bespectacled, adenoidal, and a persistent mouth breather. She plunged unhesitatingly into a confidential sort of relationship. She showed great interest in the playroom dolls and said: 'Shall I tell you something? I've got a doll like that, too.' She claimed exclusive attention and remained very close. Her play was indecisive and she seemed unusually dependent and tense under-

neath a friendly, laughing exterior. She was bothered by getting sand on her hands and preferred to chatter about trivialities. She said that she never remembered her nightmares.

Her mother was equally tense and sat with a flushed face, on the edge of her chair. In addition to sleeping disturbances Audrey was picking her fingers and had made her nose sore. In the same breath Mrs. G. said that Audrey loved school, and that it was always 'a real struggle to get Audrey up on school mornings, dressed and out of the house'. At school she was 'one of the good girls and seems quite terrified if the others are naughty'. When faced by failure: 'She seems to panic in a slow way.'

An example of Audrey's 'extreme rudeness' was her remark when a neighbour was gossiping at the open door on a cold winter's day: 'Come in at once, I have stood on the doorstep too long and got perishing cold.' Mrs. G. commented: 'It doesn't seem right—I could never have spoken to *my* mother like that.'

Comment

An 'extra-anxious-to-please manner' is a good summary description of both mother and child, but Audrey was, in addition, deeply anxious. The origin of Audrey's insecurity may have lain in her mother's memories of a 'rough' childhood. Her strictness had turned Audrey into an overtrained, docile, dependent toddler who was surrounded by doting adults.

When her father returned at 2 years, Audrey was very hostile at first, but after some months her hostility became repressed. She was over-controlled and even inhibited by day; but at night when her fears were greater and her defences less, she passed into panic states, which her alarmed parents controlled inadequately. For the most part she was unable to experience her emotions, and was subject to loss of control whenever her anxiety overcame her defences. It was unfortunate that such a child should have been treated so unrealistically at home and so idiotically at school.

Her adenoidal obstruction may have contributed to her night terrors. An anxious child waking from a nightmare might suffer an augmentation of panic because of a stuffed-up nose; but, of course, an operation should be recommended only if it is necessary for its own purposes.

A SHRINKING REACTION WITH TICS

Leonard P. (72) 8 years

Leonard suffered from tics, nightmares and general nervousness, and the school medical officer thought that his mother was 'very highly strung and has very little patience'.

The mother and father, Diana aged 12, Leonard and the maternal grandfather lived in a modern 3-bedroomed flat.

The father was 34, a capstan lathe operator by day and cinema doorman by night. He had been away, in the army, until Leonard was 3. He appeared to be stable and affectionate but Mrs. P. liked to think of him as a stern man. 'He never lays a finger on the children but just has to look at Leonard and he behaves properly.'

The mother was 31, the youngest of 5, she married at 18 because the family was breaking up, 'not that I regret it, though'. There was family friction over the care of the maternal grandfather.

Mrs. P. was full of anxious self-blame. She said: 'I'm highly strung; I'm the problem.' She wondered about her handling of the children, which she would like to alter if only they would change. There was a vicious circle of shouting and nagging, disobedience and quarrelsomeness.

Diana quarrelled a lot with Leonard (their sharing a bedroom was blamed for this), but Mrs. P. thought that they 'really' loved each other very much.

Mrs. P. had been lonely during pregnancy; labour 36 hours, birth weight 8 lb.; breast fed 6 months, easily weaned. No early difficulties. He was a lovely baby. Sometimes now, Leonard used to say he wished he were one year old and she wished so, too. She had a rigid approach, toilet training from birth, dry at night by 3. Otherwise his development was quite forward. He took quite well to his father's return at 3.

Leonard was 'nervous, squeamish, inclined to be sick or faint'; 'he makes friends only rarely and then only with quiet types like himself'. He enjoyed quiet, constructive hobbies in the home. His mother thought that his troubles dated from school entry. He rolled his head and twitched on occasion and blinked. He was long-sighted and had worn spectacles since 6. He had nightmares 2 or 3 times a week, sometimes dreaming that the walls were closing in on him. He once dreamed that the teacher shot him. Mrs. P. found him 'aggravating'. He would not go to bed without a row, and flew into a temper if told to take his elbows off the table. She felt more at home with tiny babies and said that her husband handled Leonard better than she did, but at the same time she protected Leonard lest his father's 'telling off' made him more nervous.

Mrs. P. thought that Leonard was doing badly in school, though he was in the top form of his year. He seemed to have liked it after the first year. She was offended because the teachers had noticed no 'movements' and had implied that her complaint was due to her imagination.

Examination

R.S.B. Form L. C.A. 8.1; M.A. 9.10; IQ 122; P.R. 91.5. Alexander Passalong Test M.A. 12.10; Schonell Word Recognition Test R.A. 9.6.

His persistence was marked in face of difficult performance items, but he risked little when unsure of himself.

Clinically, Leonard gave an impression of softness, he was very pallid, well-scrubbed and neatly dressed. He talked in a low voice, with subdued movements. Even his tics were restricted to a slight pursing of the lips. He seemed friendly. He selected 'snakes and ladders' and played with zest, talking the whole time about school and home. He volunteered that he got on best with his father and grandfather at home, though his mother had said earlier that the grandfather interfered with the children's upbringing. He had one friend and his favourite game was cowboys and Indians.

Mrs. P. however, insisted that Leonard was really 'a very nervous child', did not make friends and hated rough games.

Comment

Mrs. P.'s hardness in interpersonal relationships, her forcefulness and impatience, appeared to have undermined Leonard's basic confidence. Her dominance had

caused Leonard to inhibit to such an extent that he had suffered a relative failure of masculine identification, and he had failed to resolve the accompanying problem of control of aggression. His compensating but obsessional over-control had left him lacking in spontaneity but, like Audrey (71), prone to frightening dreams. His tics fluctuated as a barometer of nervous tension within. It seemed likely that Mr. P. had a better relationship with Leonard than Mrs. P. thought, and that his ability to control Leonard with a look was due more to Leonard's desire to please him rather than strict discipline, in the common sense of that word. In other words the father's 'discipline' was good because the relationship was good, but the mother's was bad because of her underlying hardness and anxious fussiness. It seems common for 'hardness' in the mother to be followed by 'softness' in the son.

Treatment was suggested but was negated by Mrs. P.'s anxiety. They arrived half an hour late for each of the three appointments they kept, and failed all others. Her excuses varied from 'crawling' buses, which Leonard said had been a visit to a teashop on the way; to visiting an ill sister in hospital, which Leonard said was accompanying her to the out-patients' department. It seemed that she feared the outcome of treatment.

DOUBTFUL MASCULINITY

Walter R. (73) 13.3 years

Walter suffered from frequent severe frontal headaches and dizzy attacks which often kept him from school, and which were ascribed to an accidental kick on the head 2 years before. He had not been concussed, and an E.E.G. had revealed no abnormality.

At his secondary modern school his attainments were average for the lowest of six streams. He was quiet and well mannered in school, a trier, well liked but lacking in confidence.

The father, mother, sons of 24 and 22 and Walter lived in a suburban terrace house and 2 married sons and 2 married daughters lived away. Mr. R. and one son operated the family business of window-cleaning. Mrs. R. worked as an office cleaner.

Mr. R. had been left an orphan in babyhood and with his elder sister had been brought up partly in a religious orphanage. He had married young, and was a conscientious and devoted husband and father.

Mrs. R. admitted to 53 years. Her parents lived nearby; the grandfather sometimes went fishing with Walter, the grandmother joined in the worry about Walter's headaches. Mrs. R. was both practical and lively, proud of her 6 successful children and baffled by the troubles of her youngest. The first 5 children had all attended grammar school.

Mrs. R. had not welcomed a seventh pregnancy after a gap of 9 years but, being well practised, she breast fed Walter for 8 months, weaned and toilet trained him with effortless ease. She had also done everything else for him until lately, when Mr. R. had gradually teased her out of her more extravagant over-protection.

As to be expected with a long family, Walter's early history was largely missing. At 3, Mr. R. had gone on war service for 5 years. Mrs. R. had evacuated with Walter for 10 months to her eldest married daughter, and the others went away with

their school. Upon return Walter went to nursery school while his mother worked. He never showed hesitation about school.

Walter was 'easy to handle', made many friends and never lacked for company. With his mother he was kind, thoughtful and attentive. Evenings found him glued to the television, and previously the whole family had gone to the cinema 3 times a week.

Walter was 'not like other boys'. He was sensitive and cried when scolded, which was rare, because of his obedience and docility. They all combined to protect and 'spoil' him, 'he takes after his mother, he's different from his brothers'. He hated rough games.

Mrs. R. had anxiously watched Walter after his accident, and whenever he looked tired or strained she would ask him whether he had a headache. The answer was sometimes 'yes' and sometimes 'no'. She had concluded from his freedom from headaches during school holidays that fresh air suited him, and asked for his transference to an open-air school. His more perceptive father noted that Walter's headaches often came on the days when his class went swimming. When he had a headache he would lie in bed, looking at books or listening to the radio. Walter had had an appendicectomy 6 months previously and came home from hospital on the sixth day. For 2 weeks his bed was carried downstairs by day and up again at night so that he should not be separated from the family.

Examination

R.S.B. Form L. C.A. 13.3; M.A. 12.6; IQ 96; P.R. 40. Wechsler Bellevue Form 1, Performance IQ 113. Alexander Passalong M.A. 14.2. Schonell Graded Word Reading Age 7.6. Holborn Scale Reading Age 7.0 years. He was right handed and left eyed.

Walter thus had no effective reading capacity, but his level of intelligence was likely to be high average.

His attitude was very passive and dependent; he was tense, though apparently friendly. He preferred to sit still and talk, mainly about his headaches, which he found difficult to describe. They would come without warning, across the forehead and temple. They lasted from a few minutes to all day, and might keep him awake at night. Aspirin did no good. He blamed the fall 2½ years ago 'I was playing rugby and got a kick on the head'.

He described himself as 'a bit backward at school', though he quite liked it and hoped to go to a technical school in order to study art. He decided to draw, but blocked at free imagination, eventually reproducing from memory a picture of an island that they had drawn in school. This entirely lacked artistic promise.

His mother did not attend, because of losing time at work. Mr. R. attended later. He was a cheerful, bouncing extravert, 'the governor of a window-cleaning business'. He thought that fresh air would cure Walter's headaches. The boy never gave any trouble, and they hoped he would go to art school.

On the other hand, Walter was 'quiet', 'finicking' and 'particular'. 'Everything must be smooth, you can't scold him or he bursts into tears.' He never got involved in a quarrel or disturbance.

It was evident that both parents were too involved in earning a living to co-operate sufficiently, so a practical approach was adopted in order to get reality into

the school situation, where his inability to read was unrecognized and when he used every excuse for non-attendance. In 6 months he had missed 77 attendances out of 216.

Remedial teaching in reading was given over a period of 4 months. His attitude was dependent, but he tried hard. Apparently for each of his hour-long visits to the clinic, he was secretly cutting a whole day's school. His parents asked that his bus fare (1s. 2d.) be paid since they could not afford it. He was full of his mother's bad health, that her heart was bad and she had had to give up working.

He gained in confidence and his reading age advanced by about 1 year during this period. His school undertook to boost his reading still further, and it was decided to let the school carry on, in view of his parent's lack of co-operation.

Comment

The ingredients of this situation were quite commonplace. Walter, the 9 years afterthought of a long family, interrupted his mother's contribution to the family livelihood. She was motherly and succumbed to the pull of another baby, but this was their undoing, because she did not release him from babyhood. The family conspiracy to keep him as their baby remained unchecked during Mr. R.'s absence, from when Walter was 3 until he was 8 years of age.

Mr. R.'s reaction to his babyish 8-year-old son was equally over-protective and unwise. Walter's 'goodness', his friendly and unthreatening nature and his mild popularity with other children meant that his total failure to progress in school remained unnoticed. His parents even nursed the fantasy of his winning an art scholarship.

Walter apparently failed to establish masculinity. He lacked a satisfactory masculine identification and grew up in a feminine world with a strong babying influence. He avoided difficulty and was easy prey to any psychosomatic suggestions, especially to headaches in connection with school. His mother's suggestions did the rest.

PSYCHOTIC REGRESSION, WITH SOME REORIENTATION

Betty E. (74) 19 years

Betty was referred at the unusual age of 19; she presented an extraordinary problem. She had a history of hospitalization and special education, and had not been able to work. Her memory was one of the marvels of the district. It was said that she could recite the names of all the Prime Ministers of all the countries and knew their capitals. She knew the weights of all boxers and the fights they had won; she could recognize tunes and play them by ear on the piano.

Betty lived with her mother and stepfather in a flat in a dockland area of London. Mrs. E. came from a healthy and successful working-class family. She herself had been a keen swimmer and netball player at school, and had won a central school place. She was working as a cleaner in the mornings and got home at 11.30. Betty stayed in bed until she came home. She slept in her mother's room, because she was too frightened to sleep on her own.

The stepfather had had a restless career and at that time was manager of a small shop. He married Mrs. E. when Betty was 11, and had been inconsiderate towards

her until recent years, when he had become much better and 'can't do enough for her'.

Mrs. E. was reticent about Betty's father. She married at 20, and her husband had had a bad employment record. He was posted away in the army when Betty was 3, and had deserted at the end of the war. Mrs. E. divorced him when Betty was 10 and remarried one year later.

Mrs. E. was 21 during pregnancy, which was normal. Birth at term, normal labour; weight 7 lb. 8 oz. They were then living in one furnished room. Betty was a bonny, easy baby; breast fed for 5 months, weaning easy. Toilet training started at one year; clean day and night by 2 without fuss. Walking began at 18 months; could say several words at 17 months. The mother insisted that all went well until Betty was 3.

Her father's call up was the end of his association with his family. Betty became jumpy and Mrs. E. was 'nervy', through bombing-out and nights spent in shelters. One night she fell while carrying Betty down stairs and Betty sustained a nasty cut which had to be stitched, but she was not unconscious.

At 3½ the jumpiness was worse, she was never still for one minute and it became a terrible problem. A London psychiatric hospital, Mrs. E. said, found nothing wrong with her. They said that Betty was like a little wild puppy and prescribed tablets, which only made her worse. A few months later the doctors at a children's hospital were uncertain whether she had chorea or not. She was evacuated to a farm about 150 miles away, where she was extremely unhappy for 3 weeks and cried every night for her mother. When Mrs. E. visited, Betty seemed to have forgotten her, so she took her back home. Betty was looked after by the maternal grandmother while Mrs. E. worked.

At 6½ 'her nerves came back', which Mrs. E. connected with flying bombs. She took Betty first to the psychiatric hospital and then to the same farm. She was just as unhappy the second time, and was tormented by a girl of 12. Whenever visited, Betty was in tears, so her mother took her home.

Wartime and other disturbances deprived Betty of most of her first 3 years at school. She attended three different schools between 8 and 10 and then an E.S.N. school for one year. She did very badly, was most unhappy, but things were equally bad when back at her last junior school, and again after a change to another junior school where she had a cousin. Betty did not mix with the others. At 12 she went to a secondary modern school, and at 15 to an E.S.N. school, for one year. It was said that Betty would never be able to work and that little could be done for her. Mrs. E. tried very hard to teach her at home and almost succeeded in teaching her 'money'.

Mrs. E. complained that Betty could not face people, seemed petrified if spoken to and could not talk. She would not leave her mother. She gave no help in the house and neither cooked nor sewed. They had tried to get her to serve in a shop but she had not the least idea of money.

She was often rude, depressed and bored, and would say: 'Can't you do something for me?'; and often very excitable and unable to keep still. There were phases of great obstinacy when nothing could be done with her. She liked music and television helped to keep her happy. Betty had many curious habits; twisting her head and mouth, and strange gestures.

Sometimes she was affectionate, anxious to please, and at other times truculent

and obstinate. She fluctuated between wild excitement and a rigid depression. She became particularly depressed before a menstrual period. In some ways she had a remarkably good memory; she read newspapers but not books. Her greatest interest was watching television.

Examination

Wechsler-Bellevue Verbal IQ 64; Performance IQ 36; Full Scale IQ 45; Schonell's Graded Reading Vocabulary Age 12.5. Schonell's Simple Prose Test, under 6 years; speed of reading, 9.5 years +; and word recognition, 9 years.

The type of discrepancy between the verbal and performance scores and the peculiar reading results were atypical of a mental defective. She did very well on the information and digit span sub-tests but failed on all the arithmetic items. She made clang associations to unknown words in the Vocabulary Test. She showed much rigidity and perseveration in performance and got no score for object assembly. Bender-Gestalt drawings indicated that her intellectual retardation and motor gestalt functions were at a maturation level of under 6.

The Rorschach record showed extreme immaturity and little capacity for social adjustment. Though slightly sensitive she lacked quantitative ability to interpret the emotional qualities of social situations accurately. Several unusual responses resulted from inaccurate perception combined with uncritical association. There was perseveration and confabulation, but no evidence of delusion. Some of her perceptual inaccuracy was due to taking minimal time for making judgments.

Thematic Apperception suggested strong needs for achievement and affiliation, but that she felt blocked in her attempts to satisfy either. During the testing she was completely uncritical, but sometimes asked 'Is that right?' without waiting for an answer. When praised she said 'Oh, I'm good at some things, my mother learnt me a lot and I listen to father and to television'.

She was a tall, bigly built and plump girl, neatly but not attractively dressed. Her fingers were nicotine stained, with nails bitten down to the quick. She started moving before being asked, but managed stairs in a particularly clumsy way.

During the interview she sat upright in a chair and showed many rather explosive repetitive movements; pursing her lips, wrinkling her brow, shrugging her shoulders, wringing her hands and occasionally a kind of convulsive shudder. Twice she suddenly stood up and shook herself, smoothed her clothes and sat down again. She was strangely alert and started to answer a question, usually appropriately, almost before the question was formulated, as if the answer bounced off her. Her vocabulary was limited and she kept repeating the same phrase 6 or 8 times, and then perseverating *sotto voce*. What she said was not remarkable, e.g. she sometimes agreed with her stepfather and at other times quarrelled. She said she was shy and nervous, and had no friends. At school she had disliked the girls because 'they talked dirty, talked rude about babies and that'. She would tidy and wash up at home when she was in the mood. She sometimes watched television and played the piano, though 'not properly'. She spoke flatly, with a set facial expression.

She had a curious habit of using words inappropriately. When asked if she had boy friends, she shook her head violently and said: 'Oh no, I won't have anything to do with them. I am not a lover of boys. No I don't have anything to do with them. I am not a lover of boys if you see what I mean. No I'm not a lover of boys.'

... Her taste in films and TV was 'I like everything, you know murders and shooting and all that, I like everything'.

In a general knowledge quiz she gave the capitals of 10 European countries unhesitatingly and when asked who was Prime Minister of France, she said: 'I can't quite think, it's Molly something, or is it Mr. France? Oh no, it's Menzies-France or something like that.' (M. Mollet had just succeeded M. Mendez-France). When asked who Mr. Menzies was she answered promptly: 'He is Prime Minister of Australia.' When asked how she knew these things she said: 'I just learnt them, I never forget them, I am a kind of memory man.'

Mrs. E. tensely complained that Betty was becoming progressively more obstinate. She seemed to feel frustrated by seeing other girls at work. She could run errands but could not manage change, and would not be taught. Mrs. E. much wanted to have tablets prescribed to soothe her.

An attempt was made to get Betty admitted into a well-known mental hospital with a big reputation for social rehabilitation. Unfortunately the hospital declined and recommended a mental deficiency colony. This was impossible, partly because of the evidence of Betty's abilities, and partly because the parents would not tolerate the idea. When last heard of Betty was being a misfit at a mental deficiency occupation centre, and it seemed that an acute social problem would be demanding solution before long.

Comment

This appears to be a case of disorientation psychosis with partial recovery. Infancy was quite uneventful, and normal except for slight backwardness in walking. Betty was, perhaps, rather placid and over-compliant. When she was 3 there was an accumulation of family discord, wartime disturbances and accident, and Betty appears to have had a very serious regression. Unfortunately the psychiatric hospital lost the records of her admission at the age of 4. Evacuation made matters worse and she made only a slow recovery upon return to her mother and grandmother.

With her mother's anxiety during the flying bomb period, Betty suffered another regression, and further evacuation was quite disastrous. Since that time Betty had 'become' more and more withdrawn and fixed in her regression. It appears that her latency intellectual orientation came about in a climate of very poor emotional relationships and she had practically no somatic or primitive understanding of the environment. She had partly filled the gaps in her emotional orientation by repetitive gestures and processes, both cognitive and motor, which served to create some order in a changing environment and to enable her to give something like a social response.

Her inability to organize perceptual experiences into a conceptual pattern having an appropriate affective content was shown in her 'memory man' act in which she amassed facts by rote memory, without any meaningful organization. She also had a very weak identity formation and body image.

In short, this was a case of primitive disorientation psychosis with a profound disorder of relationship formation,¹ but with some latency reorganization at a cog-

¹ See also Tredgold's *Text-book of Mental Deficiency*, 9th Edition. Edited by R. F. Tredgold and K. Soddy. Baillière, Tindall and Cox, London. Chapter XI. Disorders of Relationship Formation, pp. 164-225.

nitive level. Theoretically such cases should have some capacity for reorientation through repetitive teaching and carefully graduated social experiences. It was a tragedy for Betty that her case revealed a gap in the therapeutic provisions of the National Health Service.

Postscript. Two years later Betty was still faithfully attending the Occupation Centre, where she remained a misfit and her condition was unchanged. Life in the E. family was a misery of attempting to keep Betty occupied and as little disturbed as possible.

The Community Mental Health Service tried hard to supply social palliatives. Mrs. E. vacillated between despair which led her at intervals to seek admission to a mental hospital for Betty; and maternal determination which led her always to withdraw before placement could be effected. No solution to this sad problem appeared to be in sight.

PART VI

The Child of School Age

Chapter 13

School Entry and the Junior School Age

WHEN older children are being considered, it becomes less possible to select for comment any main psychological features of the period. Life becomes diverse, and a wide variety of reactions may come within the normal range during school age.

Readers who are unfamiliar with the British education system may be reminded that the age of compulsory school entry in Great Britain is at the beginning of the school term immediately following the fifth birthday. The 5-year-old school entry age is among the youngest in the world and educationists in other countries often regard this age as too young for formal schooling. In Great Britain four generations of children beginning school at 5 have created a strong expectation and anticipation of school at this age. Moreover British schools have had to adapt to the tender age of their new entrants, and there is no evidence that school entry problems are worse in Britain than in some countries with a later entry age.

Although the State is empowered to provide Nursery Schools for children under 5 years of age, the number of children attending either private or public nursery schools is possibly not higher than 5 per cent. of the age group concerned.

From the age of 5 until $7\frac{1}{2}$ children go to Infants' Schools, where academic work is introduced in relation to the child's capacity to sit still and concentrate. Junior schools from about $7\frac{1}{2}$ to about 12, have a more serious scholastic purpose. During the last year at the Junior school a selection test is made (the notorious '11+' examination)¹ to decide which educational stream children shall enter. The more academic 25 per cent go to Grammar schools where they normally work for the General Certificate of Education, Ordinary level, at about 16 years of age. A minority continue at school for the Advanced level examination, at about 18 years of age, which qualifies for University entrance and other higher technical training.

The less academic majority go to Secondary Modern schools until 15 years of age, but a very few will remain to complete the Ordinary level examination. At 13 a small proportion pass into special technical schools until 16 years of age, where they are prepared for building and engineering trades, technical draughtsmanship, and the like.

¹ At the time of going to press (1960) the 11+ examination is in process of being supplanted by other methods of selection, in many areas.

There is also a growing range of schools, both day and residential, for children with special needs. These include schools for totally and partially deaf children, respectively; blind and partially sighted; physically handicapped; emotionally maladjusted; and tutorial classes for children with various kinds of learning difficulties. Another dimension of school provision is that of classes and schools for educationally subnormal children, which include the higher range of the mentally subnormal. Children whose retardation is such that they cannot benefit from education in school are provided with occupation centres by the local health authorities.

Parents have the right, if they wish, to make private arrangements for the education of their children, though all schools are subject to inspection. Most of the State Infants' and Junior schools are co-educational and this is also true of the more recently founded Grammar and Secondary schools.

It is important to consider what may constitute preparedness for school entry. In general, a child must have resolved the tangle of his parent relationships, must have given up a primacy of demand on his mother and entered into full reciprocal relations with siblings. Having achieved all this, the child entering school is able to transfer some of his attachment to the teacher, but is undemanding and willing to share her with 20 or 30 others and to be an equal among his fellows. Successful adaptation will bring the rich reward of the secret of social living.

The child who is over-dependent on his mother may be unable to transfer even part of his attachment on to the teacher and will be quite bereft, solitary and miserable. He may fiercely repel social overtures from classmates. A few will seek to monopolize the teacher or to dominate all the other children, but necessarily such attempts must almost always fail.

Ability to take part in social life is, perhaps, more important than getting on with the teacher. In this respect town children's previous experiences will vary, from that of the society of the down-town play street to that of the one-child family in the suburban villa, where 'the neighbours are not our type'. The relationships of children in continuing groups will formalize very early into a more or less permanent pattern. Qualities of social maturity will bring the child poise and security, but leadership will depend more upon the child's motor competence and fearlessness in bodily movements.

The early social organizations of children will tend to be very inequitable. Those children who are mature enough to share in the group life as equals find rich reward in friendships and in the common life of the group. Others will be frustrated, because to them group life will be a deprivation; and frustrated children will show the usual range of compensating and other reactions. Some will be aggressive, dominating and demanding, and may provoke a reaction of group solidarity against them. In the resulting trial of strength, a determined character may dominate the group, which will then become a gang, at the emotionally immature level of its neurotic leader. More often

the embryo Napoleon will be rejected and persecuted by the others. Some children will be placatory—hangers on, useful to but not respected by the group. Others will withdraw into social isolation, etc. Within a few months of starting school, children's society therein will show most of the characteristic social roles, and once a child has adopted a particular social role it may be difficult for him to vary it in his later social groups. Unless there are very disparate factors which can be modified, such as a much older age group or a markedly different social class, school transfer used as social therapy is apt to show disappointing results.

Though this tendency for the social roles to become fixed has an important influence on the school child's social attitudes, it should be remembered that fixed role playing is less important in British society than in many others. To illustrate by an opposite: in the orthodox Confucian society of old China the social role was fixed and immutable, and could be changed only by death of senior members of the family or by natural occurrences as the individual passed from childhood to parenthood. In Confucian society a paramount virtue is to fulfil one's fixed social role. British society, in contrast, does not protect the social role of children within the family. There is no prescribed treatment of the eldest or younger son or daughter, and so on. At school it is the child's previous experience and personality that counts, and not any explicit formula of behaviour. Changes of school will reinforce the child's social mobility; successively in the Infants', Junior and Secondary school he will find a new society to which to adapt; a society in which his previous public reputation will neither help nor handicap him, unless it has been particularly noteworthy. The child passes from the lowly position of new boy or girl at each school towards leadership and responsibility, positions that must be given up upon change of school and a lowly status embraced once more. Thus the child's accustomed social role will be established by his recurrent reaction pattern. This tends to be hardened by continued success or failure to the degree that to attempt 'character training' at the secondary school level may be mere wishful optimism, in the case of many children.

During 7 years of primary school, the children's patterns of individual identification will greatly extend, with a corresponding enrichment of their identity formation. The personal identification of the pre-school child will be supplemented during 'latency' by identification with class and school, and later with the community and nation. These supplementary identifications will be personified at first. 'The spirit of St. Blade's School' may amuse the sophisticated but it is a potent force with the school child of this period. Indeed, this spirit finds a lasting echo in the societies and uplift clubs to which British people of all ages (and Americans also) are partial. The British pattern of identification, if a generalization be permissible, is based on a long secure history and upon the absence of fixed role playing in childhood. It is varied and flexible. The Englishman (and the Scots, Welsh and Irish living at home,

though to a lesser degree when in a minority, abroad) will move easily from his social role as a teacher or tradesman or workman, or whatever he is, to that of father, son, husband, ordinary citizen, footballer, town councillor and so on. He does not expect to depend upon success gained in one social role to support him in another.

Again, a long history of national security in Britain has resulted in a minimal level of drives to establish nationalistic feeling. The British child will rarely ponder the fact of being British, except possibly when living in some part of the United Kingdom remote from his own. This may be different from conditions in the United States of America where there may be an important social need to integrate new families, where there is mention of the 'American way of life' and where each day nationalistic ceremonies are held in schools, honouring the flag and singing the national anthem. There is no such counterpart in Britain. Even the custom of standing to the national anthem at theatres and public entertainments is an innovation from the imperialistic outburst of the time of the Boer War and is already dying. It is possible that after two disastrous wars in the twentieth century and the loss of security in the Nuclear Age, patriotic and nationalistic pressures upon children have increased somewhat lately.

New trends have not invalidated the general truth that, among the British, national or race identity is largely implicit in the extension of identifications and called into consciousness only in critical times. The absence of a constant external threat has meant that group rivalries have been conducted in a more tolerant spirit than would have been possible in a community perpetually fighting for its existence. Thus the British, and particularly the English, have developed team games for the organization of sibling rivalry, and are still rather shocked when they discover other countries using games as instruments of national prestige, for their own domestic sporting rivalries have a different significance. These considerations are an important part of the formative social climate of the child of school age.

'LATENCY'

The term 'latency' has been found convenient to epitomize the emotional climate of the early school period. One of the greatest of Freud's discoveries was the demonstration of the existence of a continuous process of sexual development from birth to maturity. Freud recognized the essentially sexual character of the pre-school child's intrafamilial adjustments during the resolution of the so-called 'Œdipus situation'. It then became obvious that, as compared both with the pre-school period and with adolescence, the period of life between 6 and 11 years of age has considerably less visible sexual content. Earlier it was thought that sex development was latent—hence the term—but subsequently it has been realized that it is no more valid to make a sharp distinction between the steady development in social

relationships of this period and those of sex, than to make such a distinction during the 'œdipal' period. It is true, of course, that the normal expression of sexual drives of the 11-year-old is not markedly different from that of the 6-year-old, except in virtue of a changed social setting. The term 'latency' is therefore falling into disuse, but it remains true that the period has a number of distinctive features.

Perhaps the most important of these is a very considerable cognitive advance. The early school period is the first great age of reason in child development and will result in the emergence of capacity for abstract thinking and logical reasoning. The all-round organization of intellectual processes will be far advanced, in the case of the intelligent child, by the age of 9 years. These developments enable the child to deal with the learning processes in school; to learn to read, calculate and think.

The relevant developments of earlier ages have been illustrated by reference to children's literature—to the nursery story and, later, to the exploits of Christopher Robin and his friends. When Christopher Robin reached the age of 6, the world of Winnie-the-Pooh quite suddenly lost its magic and the society of nursery animals went into voluntary liquidation. In the future its appeal would be nostalgic, as a temporary retreat into a familiar and much loved past; but Christopher Robin was ready for stronger intellectual meat.

One aspect of this new world is shown in the works of Lewis Carroll. In *Alice in Wonderland* and *Through the Looking Glass* things are very different. Here, once the magical convention has been accepted, the reader is led into a world of remorseless, hair-splitting logic; a world which, the reader may think, exists only in the mentality of lawyers in a court of law. *Alice* has only limited value as an illustration, because it was the work of a highly intellectual logician whose contact with childhood was meagre. Carroll used a highly adult intellect in his appeal to a very limited range of children. It could be said that he caricatured the mentality of the 'latency' child and he appeals more strongly to a limited adult readership than to children. Conceding all this, his works still retain a curious fidelity to the spirit of this period: to the play upon words, practical experimentation with ideas, moderation of emotion and lack of sympathy, combined with intense intellectual curiosity.

To be popular with children of this age, it appears that books must have uniformity and absolute fidelity to the convention that the author creates. It is said as a jibe that the passport to success is to discover one plot and repeat it *ad lib* in slightly different settings. An ever-popular recipe is the detective story in which a small group of children solve some mystery. This will give scope to the readers' taste for practical logical thought. Such stories have almost no human emotion, weak human relationships and little character study. All is action; and parental love is conspicuous by its absence. Another popular form is the success story of the 'From Powder Monkey to Admiral' type, in which, again, human emotional problems are steadily ignored.

The appeal of this pattern to 'latency' children is so striking that it may be surmised that in these stories and in the lives of 'latency' children generally there is a great deal of repression of feeling, as compared with earlier and later periods. This is borne out by the fact that life is generally equable at this age, but punctuated occasionally by emotional outbursts over which the child may have little control. The emphasis upon action suggests that emotionally laden drives are sublimated into activity.

Markedly out-turning children may show an enormous motor activity—they never walk but run, are never still. They are happiest in practical group activities: traditional group games that have little imaginative content and less emotion. Individually they will also be active and practical; boys will manipulate mechanical toys or take up hobbies; girls will manage their family of dolls or teach in imaginary schools with a high fidelity reproduction.

Markedly in-turning children will generally show a greater development of creative mental imagery, and some children will display a tremendous blossoming of imagination. A boy may fantasy himself as a train, with appropriate motor movements and noises. Very soon he *is* a train in all but objective appearance, and shortly after he may be far away from his starting point as a train, in a dream world of his own creation.

It is to the imaginative child of this age that the fairy tale of the Hans Andersen type appeals, with its elaboration of magic and of creative imagination into a dream world. There the conventions are not rigid and binding like those of Alice's world but are altogether more free, and liberate the richness of creative thinking of the 'latency' child.

BEHAVIOUR AT SCHOOL

Some children's school behaviour has clinical importance, partly because of misunderstandings that may bring children into avoidable trouble. We have referred above to children who take their unresolved problems of family life into the Infants' school. Mention has been made of some children's attempts to compensate by dominating the social environment, and of others who withdraw and regress. The reaction may resolve the immediate social problem healthily or otherwise, but the result may affect the child's whole attitude to school life and learning.

The typical actively out-turning reaction to unsatisfactory school adjustment is one of vastly increased motor activity. The child becomes restless and excitable, caught up in a whirl of ceaseless activity. The teachers find him noisy, a disturbing influence, distractable, unable to concentrate, impulsive, fidgety and so on. They are rarely able to see that his distractability is an intolerance of external control, that often in activities of his own choosing he may show drive and tenacity. A less actively out-turning reaction will not cause as much disturbance, but though the child may be more amenable to

discipline, he is likely to be equally distractable and unable to concentrate. The problem in either case is how to harness out-turning practical intellectual activity to the more controlled, theoretical atmosphere of the classroom. The fact that to increase the measure of external control may increase the intensity of the child's reaction to a point at which one of the parties must give way, will complicate the problem.

The actively in-turning reaction may cause less public disturbance, but is no less harmful. The child's enormous increase in capacity for creative imagination will promote his withdrawal into a dream world whenever his attention is not being held directly by the teacher. He is not interested in practical activity. Left alone he will enter his dream world in which he lives an elaborate fantasy life. 'Wool-gathering' says the teacher, as if this were a sin. This dream world has been portrayed movingly by many introspective authors who have not lost touch with childhood. Such works display the great rewards of the dream world, compared with those of the humdrum school reality. It may be very difficult for a teacher to lever the child out of his dream world when there are 35 or 40 children in the class.

The more passively in-turning child will not be such a determined escapist, but he, too, will slip into his dream world when interest begins to flag outside. In both cases the application of discipline can serve only to increase the dissatisfactions of the objective world and relatively increase the attractions of the dream world. The resistance of the in-turning, like that of the out-turning, child is notoriously not amenable to the application of mere pedagogic pressure. The only road towards a solution can be through increasing understanding of the individual child and by searching for ways of increasing his satisfaction in the objective world.

In all of the above cases the teachers' complaints are likely to be numerous. On the one hand the children will be a disciplinary nuisance—disturbing, restless and distractable; on the other hand, dreamy and absent-minded. It is mainly the lack of concentration that will bother the teacher, who will be inclined to report repeatedly 'Could do better if he would concentrate'. It would be more accurate to write: 'If he were better (adjusted), then he could concentrate.'

The third major reaction pattern, that of inhibition, presents even more intractable difficulties, though it will only rarely appear as a disciplinary problem. The inhibitory pattern, which may result from a toddler trouble of over-control of aggressivity, will tend to spread over a wide field of activity. The child will be just as inhibited in relation to the social situation in school as he will be to the educational situation. His condition may baffle the teacher. He is a good, obedient, quiet, law-abiding child; the teacher may not be in a position to notice that he cannot 'say Boo to a goose', nor stand up to his tormentors in the children's society. The child himself will conspire with his tormentors to escape all notice. In class he is neither restless nor distractable;

nor does he have to be dragged back from a dream world. His appearance is attentive and yet he achieves virtually nothing. The teacher may intuitively feel that stupidity is not the answer.

The in-turning inhibited child may be recognized by his air of rigid unapproachableness that can hardly be ignored. The inhibition of the out-turning child is more likely to be missed because, in his case, the effect of inhibition may decrease his natural hyperactivity to normal dimensions. He may appear to be an easy, moderately spontaneous child whose inhibition may show up only when extra effort is required. The result in the case of inhibited children of superior intelligence, whose results are inexplicably mediocre or inferior, may be quite ludicrous.

Almost invariably, inhibited children are regarded by less comprehending teachers as 'lazy'. 'He is idle,' they report, 'work-shy, can't be persuaded to make the slightest effort.' 'Laziness' is a practically meaningless concept in this context. It depends upon a philosophy that school work is a duty incumbent upon children, that it is morally culpable for children to refuse the obligation to work laid upon them by adults. However attractive this philosophy may be to the adult, it should be recognized that 'laziness' is not a natural feature of a child who is receiving normal instinctual satisfactions. There are great instinctual satisfactions to be gained from wholehearted participation in what school has to offer. The satisfactions to be gained from non-participation are hard to descry, perhaps they are non-existent. It is difficult not to conclude that there is something preventing the 'lazy' child from participation in life. From a practical point of view, moreover, the application of severe discipline can serve only to decrease the satisfactions to be gained in the objective world and will therefore undoubtedly decrease the likelihood of the child's inhibitions being overcome.

There is a theoretical possibility that there exists a condition of general weakness of instinctual energy in which the child may be constitutionally unable to make an effort. If this be true, the condition would scarcely be morally culpable.

Chapter 14

Problems Arising During 'Latency'

CLINICAL EXAMPLES

THE older the age range, the less easy is it to find pure examples. It is likely that a child who has had no psychological difficulty during earlier phases will cope satisfactorily with the normal experiences of 'latency'. On the other hand, difficulties may emerge that have passed unnoticed earlier; or the parents may deal satisfactorily with their young children and unwisely with older; or there may be accident, bereavement or bad social experiences. Usually trouble occurring for the first time during 'latency' suggests something not quite perfect in the earlier history; but the disturbances themselves have a characteristic interest.

WITHDRAWAL AND DAY DREAMING

Albert L. (75) 11 years

The medical officer of a small Children's Home reported: 'Albert's mother deserted 18 months ago and the children were first placed with a sister until she was found to be suffering from tuberculosis. The father is also under treatment for tuberculosis and cannot take the children. Albert is difficult and seems unhappy and withdrawn, and his father said that he had always been difficult and had night terrors. Matron feels that he is desperately unhappy.'

The junior school teacher reported: 'He is very reserved but responds well to encouragement and works well, but is sullen when scolded. He is unsociable and sometimes has made physical assaults on the other children. This may have been due to a feeling of insecurity and I feel that his real need is for friendliness and encouragement.'

His one-time infants' school headmistress wrote: 'I am in no way surprised to hear that Albert is in trouble. Albert has always had his severe personal worries and was most difficult with us at first. He sucked his hand quite a lot and a teacher had to hold his left hand whilst he was eating, otherwise he would keep that hand in his mouth even whilst feeding. He dirtied his trousers almost daily and continued spasmodically. He was timid and shrinking at first, sometimes friendly and co-operative, and at other times quarrelsome. He easily cried and was never 100 per cent happy. Throughout his Infant Course he was temperamental and awkward to manage. It was Albert I feared for most when the home was broken up but I think his troubles started long before that. I always felt he needed petting and attention and seemed to feel out of things. He rose very well to the occasion once, when he had to mind the rest of the family. Janet and Richard always got praise, and it did not help Albert.'

His attainments at his junior school were up to the level of his years, and although rather solitary, he joined with other children of his own age even if never a leader. He was not thought of as a behaviour problem in school.

Mr. L. was tall and thin, with a poor, puffy complexion. He was gentle, friendly and quiet spoken, with a stammer when excited. He seemed pathetically determined to believe that the children could not be happier anywhere else than in the Hostel. He visited every weekend and they were never upset when he left them. He could always tell whether any child was happy by looking at his face, and he knew that every child in the hostel was happy.

Mr. L. was a carpenter but, since his illness, had worked as a gardener. It had been arranged for him to teach carpentry to the boys at the hostel.

His wife's desertion had been a complete shock. He believed that a woman with 4 children was entitled to leisure and he had allowed her to go out two evenings a week alone. She took advantage of this to go out with a mutual man friend who had always taken an interest in the children. One night she did not come home. Albert went to bed at 8 o'clock and came down again with a note he had found in his bedroom. Mr. L. put Albert off with an excuse and went to his father-in-law. Later he told the younger children that their mother had been taken ill, but told Albert privately that she had gone away because 'she apparently does not like our home and does not like us'. Albert had never mentioned the subject again.

The father said: 'Believe me, I have tried to find them a home.' He could not afford a housekeeper, and no foster-home would take even 2 children and he refused to separate them. His sister had become ill. He had thought of keeping Albert at home but had been afraid of his running the streets before he got home from work. He would have liked to work at the Hostel as maintenance man and gardener, and live there.

One night, soon after the children had left home, he thought he heard Janet call him, but when he reached the stairs, he realized the children were not in the house. He thought he would go mad if he stayed there. Eventually the father and the maternal grandfather set up house together, and this remarkable arrangement had lasted for a year.

He said that all the children had always turned to him rather than to their mother for comfort, putting to bed, and settling their quarrels. 'She was an icy-cold woman, not a bit affectionate, and did as little as she could get away with for the children.' She had demanded a lot from him, but had had no time for the children. However biased the father's account, Mrs. L.'s action in abandoning her 4 children without making any provision for them is impressive. She left Mr. L. in debt, even to the extent of the bill for the clothes she had bought to go away with.

They had had much trouble with Richard, the second child—a strangulated hernia and several periods in hospital and convalescent homes; in fact, Richard had been transferred direct from a convalescent home to the Hostel, being told that his mother was ill.

The paternal grandparents had been helpful and Mr. L. used to take the children to stay with them in Kent, whenever possible.

Albert's early personal history can only be guessed at. Mrs. L. had had jaundice during her pregnancy and was very apprehensive. 'She got out of breast feeding as soon as she could, like she did with all the children.' There was no trouble with

weaning; Albert had been nervous from birth, and prone to sudden attacks of loud screaming for no apparent reason. He wanted a night-light, and his father to stay with him until he went to sleep. For years he had slept with the bedclothes over his head; he was afraid of someone tapping at the window and trying to get in. Mrs. L. went out to work when Albert was 2, placing him in a day nursery. He screamed at first but settled down later. At 3, he went to a nursery school.

At 6 Albert was evacuated with the school (and his brother Richard). After 10 weeks the foster mother wanted to get rid of them. Mr. L. thought that conditions there were very bad, insufficient food and slovenly living. He took the children back with him. Richard told him that Albert had said of his parents: 'They have sent us away for good.'

Though at one time confiding, Albert had become very reticent, to which his father ascribed his sudden outbursts. Mr. L. admitted that his talks with Albert were inclined to turn into lectures about Albert's responsibility for his siblings when they were all away from home. He often wondered if Albert knew more than he had disclosed about his mother's departure.

The staff of the children's home gave an illuminating account of this family of 3 boys and 1 girl, aged 11, 9, 7, and 5. They thought that Albert would be very upset if any of them were removed but ordinarily 'he never bothers about them'. Richard seemed to miss his father the most. Albert was odd man out; when Mr. L. visited, the children clambered round, but Albert tended to get left at the edge. He would rush out of the house when upset and stay by himself for hours. He could accept affection at times and it was thought that he might be more openly affectionate with his siblings if he knew he would not be seen.

Albert's touchiness was a byword. One day he took a long time choosing his sweets and the shopkeeper told him to hurry, whereupon he threw money and coupons on the floor and rushed out of the shop. Later he asked the matron for his coupons, but she had bought the sweets for him. He refused to have them and refused to go with the others to meet his father. Mr. L. telephoned that he particularly wanted to see Albert, as he had bought a bicycle for him, but Albert refused to speak to him. The father had to visit before Albert was mollified. A few days later when Albert asked for the key of the bicycle shed, the assistant matron suggested waiting until after tea. Albert rushed into the garden and threw a spanner through the window of another shed.

When his youngest brother was slapped by the matron at the meal table, Albert went out of the room immediately, indignant that his brother should have been hit. He always acted as escort to the younger ones on visits to relatives. He was blamed for setting fire to the paddock, and for turning another boy out of bed at night, with the mattress on top of him; but when in the mood, Albert would play harmoniously with other children.

Examination

R.S.B. C.A. 11.0; M.A. 13.0; IQ 130. He was fairly consistent, competent, and became absorbed in his task, but was not easy to deal with. Reading Age 10.2; right handed and right eyed.

He was handsome, well set up, healthy looking and well dressed. He was very remote at first, but slowly made quite a good contact. He found it extremely diffi-

cult to express himself on painful subjects, but did not seem unable or unwilling to try. He never showed his sullen side to the clinic.

He blamed his mother for everything, but said he was determined to stay with his brothers and sister whatever happened. He never made any complaint about the children's home and later it became evident that actually he was happy there.

Even after a dozen visits spread over 3 months, his mother's desertion was still too painful for Albert to talk about. Otherwise he talked freely and his whole manner was friendly, open and happy. He possessed considerable charm and liked coming to the clinic. Curiously, better reports from the home were offset by bad reports from the school. He was said to be dreamy, inattentive, and difficult, but at 11.9 years he frankly felt too big for his junior school. Unfortunately his verbal attainments were so far retarded that he failed to gain entrance to a grammar school, in spite of his superior intelligence.

Comment

Mr. L. was a conscientious, well-meaning, moralistic and complaining man, who had been dealt a cruel blow by fate—a deserting wife and 4 children to look after. No doubt he had contributed to this fate, but this is scarcely relevant. Mr. L., like Albert, had a very strong sense of loyalty to the family. There was uncertainty about when Albert's troubles had begun. People seemed to feel that he had always been nervous and difficult, but the main evidence of this came from the infants' schoolteacher who knew him from 5 onwards and who was writing about him 3 years later.

Albert's essential difficulty was that of adapting to new circumstances, it was exacerbated when misfortune demanded too much of him. But screaming on going to day nursery at 2, hand sucking at 5 and trouser dirtying on going to infants' school are not uncommon, temporarily, among ostensibly normal children. Albert was timid and shrinking for a few weeks and probably never settled completely, but there were many wartime disruptions.

It is inconceivable that this mother's relationships with her young children had been satisfactory. When a mother deserts it is likely that the heaviest burden will fall on the oldest child, and it is perhaps surprising that the situation was not worse than it appears to have been.

Albert was made to feel responsible for the younger ones when the mother went away, and this seems to have engendered in him a serious and not unjustified degree of distrust. Mr. L. struggled to make up for his wife's deficiencies, and even before she left, he had put pressure on Albert to make him responsible when his father was not there. On the whole, Albert stood up fairly well to this burden but it bent his back. Whenever the family was in trouble Albert was 'splendid'. He ignored the younger children when things were going well, but if they were molested Albert reacted like a wild-cat. But he could not support his feelings, he was very ambivalent about his father: angry but also dependent and, having a conscience, he felt bad about his anger with his father.

The aspect of Albert's behaviour typical of an in-turning 'latency' child in difficulties, was his day-dreaming. The considerable intellectual development of the period normally results in a great increase in imaginativeness. Albert preferred fantasy to his drab and unsatisfying real life, and he withdrew for long periods.

The matron sensed Albert's difficulty in living with 28 children and the staff, and he accepted with alacrity her offer of a small room with 2 beds; but his family loyalty was such that he refused to leave his siblings in order to live with his father. He must have been seriously torn between the two forces.

At the time of the first examination there seemed a serious danger of antisocial behaviour developing. However, his identification with his father was strong enough to reduce his negative drives to a recurring impulse to hurt, to kick out blindly. Fortunately Albert's lovable qualities saved him from hostile retaliation from the people with whom he lived.

The future was by no means assured. Mr. L. was dependent and ineffective—always making half-hearted schemes to work for the County Council Children's Department, or else vaguely planning to have a housekeeper and take the children home. Time passed and the children looked like remaining at this Children's Home until they grew up.

STRESS PHENOMENA

Stephen N. (76) 11½ years

The problems were recurrent headaches since the age of 5 and attacks of sickness preceded by vagueness. He was dreamy, lacked concentration, was spineless and content to stay at the bottom of his class.

The father was 46, a departmental manager in a bank. He was robust and with sporting interests, and had done very well after a hard childhood. He had left school at the age of 13, when his own father died. Mr. N. was cool in his references to his childhood family life. His family said, according to Mrs. N., that he had been much more amiable since marriage. He was an affectionate father, who tried to share his boys' life as much as possible. For example, he liked to bath Stephen (who was 11) and they had good times together.

On the other hand, Mr. N. was intensely ambitious not only for himself but even more for his children. Michael, the older, was a boy after his own heart—equally competent, and rather hard and clever like the father.

The mother described herself as 'nervous' and complained of her attacks of migraine which, it appeared later, had only come on since Stephen had developed headaches. She gave little sign of nervousness, but was not anxious to talk. She was critical about her own parents; she felt that her mother could never face unpleasant facts, and said that her father stopped work at 50 because of a mysterious complaint, but died of a stroke after 35 more years of apparently good health. A maternal great-aunt had had an uncontrollable temper and a great-uncle had been epileptic.

Mrs. N. had been thin and delicate before marriage, easily tired, and prone to bad headaches. She suffered from high blood-pressure and, upon advice, had become vegetarian. One of her 2 sisters suffered from high blood-pressure following pregnancy, and the other had asthma and used to vomit frequently.

Mrs. N. was seriously preoccupied with illness that reflected emotional tension. One gained the impression that in her family there was a mechanism to relieve intrapsychic tension by some sort of convulsion, temper tantrum, headache, and so on.

Michael, 14 years old had passed into grammar school, top of his group and was

always top of his form. Later, at 15, he passed G.C.E. 'O' level in 7 subjects. He was reputedly the more intelligent of the two but they played together very well, mostly outdoors.

Later it became apparent that Michael was also rather hard, inclined to tease Stephen whose sense of humour was much superior to his own. He established an ascendancy over Stephen who, passive and good natured, was an ideal doormat. They shared friends in common because Michael had none of his own.

Mrs. N. had toxæmia of pregnancy with Stephen, who was premature and small. Breast fed for 2 months, Stephen took to the bottle but could not digest fat satisfactorily. There was much vomiting and the fat content of the milk was reduced. He also refused halibut-liver oil and never took fried foods if he could avoid them. He walked at 20 months, but was not retarded otherwise. He had a transient phase of stammering at about 2½. He was clean early but wet his bed until 4, ceasing spontaneously when he was kept in bed for some minor illness. Mrs. N. commented: 'Maybe it was because I gave him more love at that time.' Chorea was suspected a few days after he started at the infants' school. He developed jerky movements and their doctor put him to bed with sedatives, saying later that he had 'just escaped' chorea.

Stephen's headaches started soon after he had gone to infants' school, which he tolerated with difficulty. At 7 he stayed with his maternal grandmother for a few months, with Michael but without his mother; and was happy at his temporary school and free from headaches.

He quite frankly disliked his junior school. He was particularly bad at mathematics for which Mrs. N. blamed a woman teacher at the infants' school, who frightened Stephen during his first few months there. When out of class he was sociable and made friends easily. He was the soul of friendliness and good nature, and had a cheerful smile for everybody. It was extremely doubtful whether he would pass his grammar school entrance examination in 4 months' time.

Examination

In view of his indifferent school reputation, his result on the R.S.B. was electrifying. Form L. M.A. 16.6; IQ 152; P.R. 99.7. He was left eyed and right handed. Stephen had undue difficulty in reading and, particularly, in writing, which had obviously been a very great labour for him. His spelling was deplorable. Otherwise he had a normal scatter, with a slight bias towards items demanding subtle use of words. His vocabulary was wide and it seemed that his interest in words might not be limited to their value as a means of communication. He had a tendency to be overcome with sudden inertia in intellectual effort.

His low spelling age of 12.3, might have reflected a residual crossed laterality difficulty. His slow and laborious writing would make his class work appear careless. He disliked school and achieved unbelievably mediocre results. He was bored with English, he hated 'the way we do things five times over', but he felt he had nothing to say, which was in marked contrast to his high verbal ability and his interest in ideas verbally expressed. There was no evidence of deep distress, but rather of withdrawal of effort because of lack of success.

Wechsler Bellevue Intelligence Scale, Verbal IQ 135; Performance IQ 106; Full Scale IQ 120+; P.R. 98. He persistently rushed at items, especially at arithmetic,

which pulled down his score. He seemed excited at the end of the test, but suddenly changed to passivity in the waiting-room, where his mother dressed him, fastening his belt and buttons.

Stephen's Thematic Apperception included much, mainly hidden and indirect, conflict; but the hero of the story invariably turned out to be a bit of a fool, and usually ended disastrously. This was suggestive of no great self-confidence, and of defeatism or lack of buoyancy. Perhaps his value system was not clearly formulated and he was, as it were, knocking down for himself the things he cared about.

At this period, Stephen was tall, red-headed, awkward and clumsy to an extent that was proverbial in the family. He gave the impression at interview of being vague but was quite informative, if somewhat detached. School was 'all right' but he preferred holidays, when he could go out on his bike, pursuing his passion for nature study. He kept fish in an aquarium in order to watch their development at various stages. He had no idea of what he wanted to be after leaving school. His favourite sport was swimming.

He said he was always quite well 'except for these headaches', and described an attack in detail. He felt not too well on waking; this feeling usually wore off but came back as a severe headache at about 10 a.m. The pain went from the forehead to the back of the head, slightly to the left side, and was steady. It was made worse by reading and bright lights, but sometimes fresh air helped. He saw no colours nor light flashes, nor had blind spots. He usually vomited about an hour after the onset. He would sleep for 2 or 3 hours and the headache would disappear by about 8 p.m. He would then feel wakeful and hungry, and would be fine next morning. Sometimes his early morning malaise would go off without developing into a headache, and the regular use of phenobarbitone had helped. He said that his mother had similar headaches. During the whole interview he fidgeted and did not sit still, and was distant and defensive underneath his surface geniality.

In spite of her preoccupations, Mrs. N. was intelligent, responsive, friendly and eager to help. She felt that Stephen's headaches distressed him but she was more concerned with his inability to concentrate, and lack of achievement. She compared the two boys: Michael was placid, but Stephen worried and wanted to be like Michael, whom he put on a pedestal. 'Michael doesn't give anybody any praise—he's that type.' Stephen was much sweeter natured. He rarely showed temper, being obedient and easy to handle. She injected some of her own feelings into saying about his headaches: 'I can't understand it; we're such a very happy family.' She had a bogey about school teachers. Referring to an incident nearly 6 years before at the infants' school, the mother said: 'I do think it was wrong to treat him like a criminal because he was sick.' Lately Stephen had been compared in public with his brother, to his great disadvantage, and this was not the first time. Stephen was so jerky and jumpy that his mother had told him to give up music practice, as his hand was not steady.

Later on, Stephen revealed himself as being neither distant nor reserved, but merely a slow starter. During his treatment which is outlined in Chapter 19, he was the soul of geniality and friendliness. He was slow to drop an intellectual attitude to play, and had a correspondingly marked phase of regressed play before he became constructive. From then on he steadily improved and his headaches became much

less of a problem, and eventually no longer worried either Stephen or his mother. He was much more grown-up and confident.

In spite of doubts, he won a place in a grammar school and even agreed to go to a different school from that of his brother.

Comment

There was such a wealth of material that his presenting symptoms of recurrent attacks of headache and vomiting, combined with lack of effort at school were easy to overlook. These had been regarded rather complacently by all concerned as due to cyclical vomiting and laziness, respectively. We may anticipate a short discussion of the nature of cyclical vomiting which will follow this case, by making the suggestion that it may have some relation to an explosive release of tension, and this notion finds support in the strong story that, upon starting school, Stephen 'just escaped' chorea. However useful as a pseudo-explanation, the concept of a narrow escape from chorea is a medical absurdity. Stephen's jumpiness at this period was more likely to have been an explosive release of tension. His cyclical vomiting may have represented a periodic release of tension that had been made worse by emotional strain, and particularly by maternal anxiety. Let us re-examine the complicated tensions within Stephen's family.

Mr. N. was a successful self-made man who had set out robustly to build the pattern of his own married family life very differently from that of his hated childhood memories. Mrs. N., in striking contrast, had had a valetudinarian father, almost all her relations had some pet ailment, and she herself had her menstrual troubles and her migraine.

Mrs. N. strongly identified Stephen with herself, and, less strongly, the thrusting and successful Michael with his father. Later, it became evident that she fantasied that she and Stephen were 'a cut above' the other two. Like the Pea to the Princess, migraine to Mrs. N. was evidence of a more refined bodily clay. She would have felt that success was vulgar, had she not despised her father and admired her husband.

In Mrs. N.'s view, delicate people of more refined stamp were not fitted for the stern competition of life and she accepted Stephen's low level of personal aspiration. She sabotaged effort and independence: 'You're sure you feel well enough, dear?' and by anachronistic acts like buttoning his overcoat in public when he was 11. Interestingly, Mr. N. took the situation at his wife's valuation, but could not completely conceal his disappointment from Stephen that the latter was not doing as well as Michael, a disappointment that Michael did not fail to rub in. For all his warm-heartedness, the father valued success the more highly because of his own grim childhood.

The over-protected Stephen reacted to school entry by a quasi-hysterical conversion illness. Later, his in-turning temperament and tendency to withdraw caused a serious inhibition. When he underwent the usual intellectual development of 'latency' Stephen became vague and dreamy, spending much of his time at school wrapped in fantasy. There his great ability passed unnoticed and he was allowed to remain at an extremely low level of aspiration.

Stephen's dreaminess and inhibition at school provoked no bullying or teasing among more robust, out-going boys. Everybody always liked Stephen and he was a popular, if passive, member of any group. He was never a threat to anyone's

interests, he never competed, he never harboured an ill-natured thought about anyone and he was always responsive to friendliness. He was too nice even to be exploited!

Stephen's crossed laterality must be borne in mind. Though evidence is conflicting, left handedness and right eye dominance may greatly add to the learning difficulties of a child who, like Stephen, is making a poor adjustment to the learning situation. Crossed laterality could not be the *explanation* of Stephen's troubles, but it would serve to aggravate his difficulties in learning the more mechanical aspects of reading and writing.

Stephen's treatment, subsequent entry to grammar school and in due course, to university will be discussed further in Chapter 19.

CYCLICAL VOMITING

This will be an appropriate place at which to discuss cyclical vomiting, a common condition that consists of periodic attacks of malaise, headache or nausea, often accompanied by high temperature ($102^{\circ}+$) and/or abdominal pain, furred tongue and recent constipation. The number of innocent appendices that have been sacrificed upon the altar of carefulness must be legion. The frequency is severe if it exceeds one per month. Attacks usually last for a few hours, rarely more than 12. The victim usually looks pale and heavy eyed (except for a flush caused by high temperature) and is commonly quite incapacitated. Often the onset is marked by uncontrollable yawning, sometimes by unusual hunger or desire for sweets. Vomiting or sleep may relieve the attack, and the victim will feel 'washed out' for some hours. A minority will feel hungry immediately the headache has gone and a few will be almost hypomanic.

The origin is obscurely connected with a phasic irregularity of metabolism, possibly of fat. It has something in common with patterns of explosive discharge of tension, normal in the case of laughter or anger, and pathological in that of epilepsy. The parallel with migraine is tempting and some of these children later develop migraine, 'sick headaches', menstrual pain or skin allergy.

A common misconception has here obscured clinical reality. For unknown reasons a habitually pallid face is often associated with the general inhibition of aggressiveness common among British children who are subjected to heavy family emphasis upon conforming behaviour. However, many mothers will associate pallor with headache, and may ask the child at frequent intervals whether he has a headache. Few children can indefinitely withstand such suggestion. There is an impression that pallid children are subject to 'sick headaches'; but as far as the headaches of cyclical vomiting are concerned undue pallor is not invariably reported.

Nor can cyclical vomiting be given a direct relationship with emotional tension; but it is possible that parental anxiety will increase the likelihood of attacks of headache in children who are prone to cyclical vomiting.

SELF-COMPENSATING DELINQUENCY

To classify delinquency with difficulties arising during 'latency' is to act arbitrarily, but according to English law (1960), 8 years is fixed as the minimum age of partial responsibility. It is probable that delinquent behaviour that occurs after the age of 8 has roots in attitudes and experiences of a much younger age; but many children do not present problems until after the age at which they can appear in a juvenile court.

Vera P. (77) 11½ years

The headmistress of the grammar school to which Vera was due to go 2 months later, asked for a Child Guidance examination because of reports of petty pilfering and great anxiety at home. Vera's stepmother requested a delay until Vera had settled at her new school, and 3 months later requested a further postponement. Two months later still, the stepmother wrote the following letter:

'... Vera has let herself down again. On two consecutive evenings while her father was out, she has helped herself to money from his coat pocket hanging in a lobby. On being questioned she at first denied it, but admitted taking it when her father told her that on the second evening he had taken note of the amount in his pocket before going out. The stolen money had been spent on comics and sweets.

'My husband and I feel particularly badly about this fresh outbreak, after a fairly long period. Moreover, on the previous Saturday we took her to see a suitable film, buying her ice-cream, etc., and it is only a fortnight since she returned from 2 weeks' holiday with her grandparents in the country.

'For her birthday in March, we bought Vera a puppy with the idea that it might help her to have a pet of her own to make a fuss of. She was also allowed to invite some of her friends to a party.

'We have also bought a piano, partly with the idea of having her taught to play.

'I have given this information now, as it is easier than trying to remember everything at an interview.

'Should you wish to see me, either alone or with Vera, I could probably arrange to leave work at 3 o'clock by cutting my lunch hour in half.'

Vera was thought at school to have good general ability, to be eager to do well and to be upset at lack of success. Her behaviour was 'good', she studied to please the staff, but was lonely among the other girls.

Vera had stolen little things at home—trinkets, sweets and odd coins, ever since her father's remarriage, 2½ years earlier. Vera was watched, tensely, and she made little attempt to conceal her thefts. Many of the objects were quite useless to her, except the money which she spent on sweets. Punishment was mainly by lectures, threats, deprivations of pocket money and treats, and sending to bed. Once she had stolen chocolates from a friend. Since going to her new school Vera had once stolen sweets from her stepmother but had twice 'lost' her weekly dinner money on the way to school. The first time, repayment had come out of Vera's money box, the second time out of her 1s. 6d. per week pocket money.

Mr. P. was 47, a technical storekeeper in a manufacturing firm, and an ex-regular quarter-master sergeant. He was rigid, well-meaning but not understanding; e.g.

when he decided that Vera ought to make more friends, Vera was 'allowed' to invite some of her school friends to her birthday party. It apparently required a birthday to justify the inviting of friends into this home! He then decided that Vera should be a Girl Guide and he wrote to Guide Headquarters, who referred him to the District Commissioner, who suggested a company.

Vera's mother had died suddenly 4 years previously, at the age of 46. The step-mother was not generous about her; she said she had been a good housewife, home bound and domesticated, but good company. She was alleged to have been over-indulgent with Vera.

The stepmother, aged 35, had worked in the same firm as Mr. P. and, during one of the periods of wartime domestic confusion, she had shared a flat with Vera's mother when Vera was a tiny baby. She had lost her first husband in the war after 5 months' marriage, during which she had had a miscarriage. She seemed to be very attached to Mr. P. but cool and critical about Vera.

Vera's 21-year-old brother had recently married and was living nearby. The P. family occupied a flat in a quiet suburban road.

Little was discovered about Vera's early history. She had always been a big, healthy and forward child. Mrs. P. considered that Vera had 'had her own way right from the beginning', and said that she had been found guilty of theft at the age of 3. When her mother died, Vera lived with her paternal grandmother and had a number of changes of school, for no clear reason.

Mrs. P. seemed afraid of Vera, to dislike her and to be on the look-out for signs of the mother's temperament in her. She felt additionally that Vera had 'got the upper hand' with her grandmother. Vera's return after her father's remarriage was inauspicious. Mrs. P. prepared a home-coming party and described with feeling, even 4 years later, the cake and the presents, and Vera's ungracious, derogatory acceptance.

Later, they had specially arranged ballet lessons for Vera, but denied her participation in a school party visit to France because of the cost of house redecorations. Vera had been reserved with her stepmother and would never call her 'mother'. The home was in a state of siege, since the parents were constantly on the watch lest Vera stole something. She got on well with adults, but not with her own age group. She adored babies and was much in demand as a pram pusher.

Examination

R.S.B. Form L. C.A. 12.1; M.A. 16.3; IQ 134. Kohs' Block Design M.A. 13.9. Vocabulary S.A.I. Vera showed ready generalization, clarity of thinking and some special mathematical facility. She was impulsive and lacked self criticism, and her quality of effort deteriorated rapidly in frustration.

She was a pretty child with a rounded face and curly brown hair. Though expressionless, she was superficially friendly. She talked volubly of her many schools, her grandparents, her puppy and her ambition to become a veterinary surgeon. Possibly she was talking hard in order to keep the conversation off her stealing, for when questioned eventually, she burst into tears. She became angry and dashed away her tears with grubby hands, streaking her face. She complained that the slightest trouble made her cry; she simply could not control her tears.

Stealing was the sore point. She stole because she was lonely, unhappy and angry,

and then felt upset with herself for doing so. She was bitter that her stepmother should make her pay back out of her 1s. 6d. pocket money and almost justified her stealing on this ground alone. She became heated and angry about her stepmother who, she said, was moody and blamed her for everything that went wrong. She had a particularly urgent sense of injustice over a 10s. note which she was wrongly (according to herself) assumed to have taken.

Vera was less overtly hostile about her father but she was hurt that he sided with her stepmother. On the other hand she felt she was letting him down by her stealing. Her only positive references were to her own mother, whose memory she appeared to have idealized.

Her too-easy weeping always let her down when she least could afford it. Apart from these troubles she did not complain, she had many friends, but her main hobby was to read two library books each week.

Interviewed at that time, Mr. P. seemed to be pedestrian and unimaginative, almost a stranger to his daughter. He was astonished at being asked whether Vera was good company, a possibility that had never occurred to him. He was sceptical about her tears, and it was Vera's 'insensitiveness' to her 'wrongdoing' that upset her stepmother. Vera lacked physical courage and would let herself be knocked about by quite small boys, but Mr. P. did not realize any implications of this remark. He made heavy weather about her lack of friends, but revealed that they did not let her play in the street and allowed her friends in the house only by formal invitation of the stepmother. They fined her for 'gross misbehaviour'.

The stepmother was very attached to her husband, but she felt guilty because she had loved him in her predecessor's lifetime. She had had an unhappy life, her own mother had been a great burden, and three men in her life had been killed. She had wanted not to be 'just stepmother' to Vera and complained bitterly that she could make no headway with her.

Comment

Though there lacked evidence of a deep character disturbance in Vera, it seemed only a matter of time until her stealing would involve her in the Juvenile Court. Among the commonplace ingredients of the case was that of a well-meaning, conscientious man who lost his wife suddenly, who married an old friend after a decent interval of 2 years and gave his 9-year-old daughter a home again.

There was no evidence of difficulty before Vera returned home. The report about stealing at the age of 3 reflects upon her stepmother's attitude rather than upon Vera. The stepmother had never forgiven Vera her ungraciousness about the homecoming party.

Why was the stepmother so consistently ungenerous? First, her guilt over her earlier attachment to Mr. P. made her depreciate her predecessor; and she was jealous of all influences in the family predating her own. Second, her experience of losing three men added to her possessiveness and guilt. Conscientiously she tried to make up for lack of spontaneous affection by calculated actions that were not acceptable to Vera.

Mr. P. saw only his wife's show of good will and not Vera's emotional starvation. Vera regressed and, like her parents, mistook little material pleasures for love. She helped herself to whatever she could find. This increased her guilt, which increased

her need to steal. The social danger was that her depredations would overstep the family boundaries.

Joan E. (78) 10.10 years

In Joan's case there was even less parental goodwill. Her headmistress wrote: 'Joan is her mother's child by her first husband. Joan speaks of an older sister who was not brought back from evacuation and I am not sure that the stepfather knows of her existence. Joan went from her evacuation billet to a boarding school where she was under close supervision. Now, every day on return from school she finds an empty house, gets her own tea and settles down alone to her homework.

'Apparently she is not kept short of money and her pilfering is not due to necessity. She is punished quite severely, I believe, shut in her room and sometimes "chastised" by her stepfather, to use his own term.

'When she first came to school she was sullen, rude and uncouth; but has improved out of all recognition, except that she takes money and small belongings from other children and lies glibly to cover her tracks. In some ways, though, she is disarmingly honest. She is very intelligent but restless and her work lacks organization. She makes friends with the other children. Her mother seems only too ready to accept Joan's guilt even if proof is lacking. Her young stepfather seems to be at sea in handling his big stepdaughter.'

Joan had lived with her mother and stepfather in a comfortable flat for the past 2 years. At home she stole mainly sweets and foodstuffs, to the extent that the larder was kept locked. She usually did not eat what she had stolen. She would also pocket any money left lying around, though her opportunities were few. Occasionally she made a small haul from overcoats, and this had happened also at school. The stepfather used regularly to search Joan's room and found that she made little or no use of her ill-gotten gains, except money with which she sometimes bought sweets for other children. She could be trusted to bring back the correct change from shopping.

Joan's mother was a severe, unfriendly person, consistently unco-operative and uninformative. Her age was about 35. She had married in her early twenties and her daughter 2 years older than Joan had been adopted when the marriage broke up. The mother was extremely reticent about her earlier life and only said of Joan's father, that he was impulsive, had a violent temper and the marriage was never happy. Joan never saw him again.

The stepfather was aged 28. He worked for a firm of business efficiency consultants. He was a solid young-looking man, with a well-meaning, if imperceptive, attitude to Joan.

Pregnancy and birth were normal; Joan was breast fed for some months. They lived with the maternal grandmother and probably Joan's father never really lived with them.

The marriage collapsed when Joan was 18 months old. She was placed with a friend who had two boys, but at 7 was so 'difficult' that she was sent to a boarding school. (This must have been about the time of her mother's remarriage.) There were many complaints about her stealing at school, which the mother scarcely believed. At the age of 9.8 years Joan went to live with her mother and stepfather.

Mrs. E. described Joan as bright and lively. She was 'over confident', sure of

passing exams, and certain she would not be detected stealing. She 'thinks there is nothing she is not capable of and she doesn't have any fears'.

Two threads appeared throughout Mrs. E.'s description. Joan was friendly and very affectionate. She talked a great deal and liked to help her mother in the house. On the other hand, she was quiet and played alone, as Mrs. E. discouraged her mixing with other children 'because she picks up bad habits easily from them'. She would stay in bed on Sunday morning playing with her dolls, but was packed off to afternoon Sunday School. She did not belong to any club or organization. 'She is very bossy with other children, and must be top dog.' They thought her sly, secretive and untrustworthy, and the house was fortified against her depredations. But alternatively, she never worried about anything for long, and was gay and irresponsible.

One probably cannot have things both ways, legitimately.

Examination

Joan was self-assured under test. She was unselfcritical, not quick and with no great verbal facility, nor did she persevere. R.S.B. Form L. C.A. 10.10; M.A. 12.0; IQ 111.

At her first psychiatric interview Joan was pathetic, shabby and untidy, unresponsive and suspicious, and sucking her thumb. She looked depressed, guilty, and her eyes filled with tears when she was spoken to. She had a need to talk but remained hostile and suspicious. At first she admitted only to taking food and sweets at home.

However, when given painting to do she turned spontaneously to smile at the doctor and even started teasing 'I won't let you see what I'm painting'. Her manner became 'bossy' and 'important' and she talked volubly about her affairs. She liked her present school, but not her boarding school. She wanted to see her sister and her father. Her free choice of home would be to live near the seaside with her mother, but she seemed in doubt about it. Her stepfather was 'a nice man', but she wondered whether her mother really loved her.

She remained wary and became hostile at the least false step. Apparently she was very miserable about her stealing and felt in the grip of forces too strong for her. She appeared sincere in saying that she hated herself while stealing. Her habit of rolling her eyes and frowning suggested a strong and disturbing fantasy life.

The mother, at this time, seemed drawn and tense, but was not openly unfriendly. She minimized everything. Certainly Joan had spasms of stealing every 6 months or so, but only once outside the home, and so on. She was highly strung, excitable with other children, but gave little trouble. She made and kept friends, was generous, impulsive, lively and happy; but unpredictable withal, depressed momentarily when in trouble. It was her husband who worried. Admittedly there was 'a small gap' between Joan's return home from school at 4.30, and the stepfather's return at 6 p.m. and they locked up all the food in the house.

The stepfather looked young even for 28. He was pessimistic that Joan's improvement was merely the result of fewer opportunities. Joan was happy except when she did not get her own way. He had tried reasoning, moralizing, ridiculing and thrashing, but nothing touched her. Though forgiving and affectionate, she 'has

an incredible faculty for putting things at the back of her mind and forgetting them'.

The ingredients of this situation were unpromising and treatment proved impracticable. The parents agreed to fill up the 'small gap', but did not do so. They deferred further action until after Joan had taken her grammar school entrance examination which, surprisingly, she passed one year later. The standard of the grammar school was higher than Joan's top level of attainment, but little happened for a year, when the school became alarmed about her steady depredations. These coincided with the arrival of a new baby. Threat of expulsion drove the parents back to the clinic but they delayed examination for 6 months, and then reported all quiet and that Joan had been very nice about the new baby. The school confirmed the lull in thieving and reported a remarkable improvement in the quality of her work.

Six months later the steady prevalence of small thefts ascribed to Joan caused her ascertainment as maladjusted and she was sent to a boarding school where, for 18 months, she found happiness. Unhappily the school suddenly closed down, and it was arranged that Joan should complete her General Certificate of Education at a local grammar school. After 6 weeks at the new school Joan was suddenly removed by her parents and started work as an office clerk. She looked the picture of misery, but said that she fully concurred in this decision. Then, abruptly, she burst into tears and left hurriedly repeating that, really, there was nothing wrong.

Six months later her mother charged her in a juvenile court with being 'beyond control'—making use of an archaic and unhelpful clause of the relevant Act. Joan was placed on Probation in a working girls' hostel 15 miles away from her home. It seemed unlikely that this would be the end of this unhappy story.

Comment

This case unfolded inevitably like a Greek tragedy. Joan's infantile relationship with her mother had been quite good, and she had a basic capacity to enter into loving relationships; she suffered depression and frustration by the treatment she received. Later, the quality of maternal love was decidedly poor, as shown by the adoption of the older girl and Joan's placement away for 7 years when the parents' marriage broke up.

While at the foster home Joan was vigorous enough to be a nuisance; but at the boarding school her depression led to miserable self-compensating stealing. Her return home was a grudging parental concession to her delinquency. To lock up all the food and then make Joan stay alone in the house from 4.30 to 6 p.m. every evening seemed to be either criminal folly on the mother's part, or else unconsciously determined by a need to provoke trouble.

Joan's halcyon 18 months at boarding school demonstrated her still remaining capacity for affection; but when she returned home she demonstrated her resentment by provoking that 'beyond control' charge.

It seemed that Joan would be in very serious moral danger throughout adolescence. Her hunger for affection and her capacity to respond would make her the willing dupe of any predatory male. Her capacity for prudence and for making a wise choice of mate was more than problematical.

The following five short cases further illustrate 'latency' problems.

HYPERKINETIC AGGRESSIVE REACTION

Frank S. (79) 13½ years

Frank was referred because of 'erratic behaviour in school since his return from Approved School a year ago'. He had brothers 2½ and one year older; sisters 1½, 3½, and a brother 5½ years younger. His parents had separated when Frank was 8 and his mother had remarried.

Frank's father had never supported his family, but his mother was competent and warm-hearted and managed her large, young family easily. Frank was evacuated to a residential nursery with his next older brother, from 3 until 6 years. When he returned home, his parents' marriage broke up and there were severe housing and economic difficulties. He got into trouble with a gang and his mother charged him with being 'beyond control'—that curious anomaly of English law. He was placed on probation. Two months later he was charged with breaking and entering and stealing. He was sent to an Approved School for 4 years.

Upon return home he found his mother remarried and rehoused in an adequate flat. The stepfather was a kindly, elderly man. Frank's next older brother, who was educationally subnormal, had returned to his wartime foster home by mutual consent. The oldest brother was constantly in trouble with the police.

Mrs. S. thought that Frank's behaviour was in most respects that of a boy 3 or 4 years younger. He was incredibly naïve in many ways, but generous and helpful in the home, though noisy, rowdy and erratic. He wetted his bed and occasionally soiled.

Examination

R.S.B. Form L. IQ 105, reasonably good verbal ability; but very poor school attainments, particularly in arithmetic.

Frank was cheerful, almost euphoric. Things were fine at home and he liked his 'Pop'. He had been temporarily cast down by a threat of return to the Approved School, but he consoled himself with a promise of a master to take him down a coal-mine if he returned there.

A combination of probation supervision and child guidance group treatment helped Frank for 9 months; then his oldest brother disappeared with other boys to 'live rough', *en route* as it transpired, to Borstal. The next brother went to an Epileptic Colony, which left Frank exposed as the oldest at home. His boredom with school increased; he had only 6 months to go and was irretrievably backward. School was a positive danger to him, for he was frustrated and constantly humiliated there. He turned to the street gangs for his fun. It would have been wise to excuse him school attendance and give him worthwhile technical training, but the Education Act was too rigid for an unimaginative local education authority to manage this. Frank was duly committed to another Approved School, though 5 years earlier he had failed to make progress at the previous one. The magistrates had no alternative. Fortunately Frank was treated with imagination at the school, licensed after one year to a working boys' hostel and found suitable work under protected conditions. Two years later he visited the clinic and reported that all was well. Although he was extremely young for his 18 years, his genial good nature and the unrelenting social services had helped him to weather the storm.

Comment

Frank escaped from complete disaster through his capacity as an infant to form good basic interpersonal relationships. However, he was particularly backward both in motor and social orientation. Probably when Frank went to the evacuation nursery at 3, he regressed severely, failed to adjust socially and lost a great deal of motor skill. When he returned home at 6 he was backward and clumsy. Life at a boarding school from 8 to 12 set him back further, relatively. At 13½ he was an untidy, gangling youth with a wide, good-natured grin, a hoarse croaking voice, and feet and hands that he could not quite manage and was never quite sure where they were. He made himself at home—strictly at his own level, in any group, irrespective of its composition. He had no notion how to comport himself. Insatiably curious, he reached out at anything that caught his eye, examined it with delight and was apt to break it, purely by accident. He was quite capable of pulling the clinic receptionist's hair till she cried out, but with only the intention of spreading happiness.

One incident particularly illustrates his social ineptness and his vulnerability. He disappeared one night, in order to tease the doctor. A few minutes later while looking out on to the street, vaguely wondering if Frank were hiding outside, the doctor saw to his horror, that the coal hole cover was levitating from the pavement to reveal the gaping coal chute. A girl walking by paused to look, but suddenly walked on, was hit smartly on the back of the calf by a lump of coal and pursued down the street by hoarse, demoniac and subterranean laughter. Frank was the most misunderstood and misunderstanding child known to the author.

It will be noted that though this difficulty arose from circumstances operating around the age of 3, it was not until late in 'latency' that removal to a boarding school provoked a reaction in Frank that, on the surface, resembled a deep character deformity.

EXCITABLE, OVER-ACTIVE

Daniel L. (80) 7 years

Daniel was referred on account of scholastic backwardness, restlessness, lack of concentration, constant interference with other children, night terrors, poor appetite and destructiveness.

This Jewish family of father, who was a cab-driver, mother, the maternal grandmother, and a brother aged 15, lived in a small suburban house. Mr. L. was a healthy, happy-natured man, good with his children. Mrs. L. thought that she had been 'highly strung' as a child. The brother was a dapper youth, a hairdresser's apprentice who disliked the idea of a 'dirty' job.

Mrs. L. ascribed the family troubles to the birth of a 'blue' baby 3 years before Daniel's birth and who lived for one year. She had worried very greatly during her next pregnancy in case she was 'not the woman to bear children'. 'I never felt any labour pains, I was in such mental agony.'

In retrospect Mrs. L. thought that Daniel had been normal until he went to school, when in the course of one year he had had chickenpox, measles, whooping cough, mumps and recurrent tonsillitis. Sleeping became a great problem, with

sleep-walking and repeated night terrors which he could not recollect next morning. Tonsillectomy 2 months ago had improved his night-time troubles.

Mrs. L. thought that Daniel had never been hungry. 'The day he comes in and demands something to eat will be a great day.' She made him tempting dishes, but had to feed him in order to get enough down. She had him at home for midday dinner because she could not trust him to eat at school.

He disliked school but made no objection to going. He made no headway at all. He loved painting and drawing, but preferred playing outdoors. His mother said: 'I feel he is afraid of something, what it is I cannot say.' The family atmosphere seemed placid, with the mother as the only worrier.

Examination

R.S.B. Form L: IQ 98. His test result revealed nothing to account for his complete reading failure.

Daniel was a well made boy, but small enough for a 4-year-old. He was subdued and tense while waiting with his mother, but lively and pert on his own. His play was energetic, digging holes in the sand tray and running toy cars along. His movements were quick, decisive and hyperkinetic. His play was practical and realistic, and he commented on everything he saw. Contrary to school reports of no concentration, he became absorbed in sand-tray play of his own devising and might have continued indefinitely. He remarked spontaneously: 'I don't like my brother, he hits me in bed.'

At this time Mrs. L. thought that the tonsillectomy had cured all his troubles, but in contrast, she was terrified about his transfer to the junior school due in 4 months' time. She spent most of the interview talking about the death of her 'blue' baby.

Comment

In spite of anxiety Mrs. L.'s maternal nurturing had evidently been adequate for the establishment of Daniel's basic interpersonal relationships. The independence of the toddler age had raised her anxiety and imposed an increasingly severe burden on him. He was seriously handicapped by his incapacity to adjust when he went to school, to which he reacted by hyperkinesis and distractable behaviour. This did not appear to be a deep-set difficulty; but a few months later Mrs. L. unsuccessfully attempted to delay by one year his transfer to junior school. She was incorrigible.

DISAPPOINTED PARENTS

Roger N. (81) 11 years

Roger's father described him as 'the despair of every school', he had no idea of how to work and was resistant to it. He wrote to the headmaster: '... Roger needs all the help that anybody can give. The two people who can best give this help are you, his Headmaster, and I, his father. Mother love he has always had, and only God knows how this has been forthcoming in the face of ingratitude that could have turned anything less into hate. Assuredly blood is thicker than water. ... He seems continually to be kicking against the pricks to get attention and vivid imagination and exaggeration continue to cast doubt on his veracity. ... For your part I do earnestly ask you to help this lost sheep till he finds his feet. ... I shall

be very grateful for the helping hand of experience that I know you will not withhold.'

Roger lived with his parents, brother of 13½ and twin brothers of 8 in a small villa in a country dormitory area. Mr. N. was a London business man, with obsessional qualities. He blamed his wife's emotional instability and jealousy for the tense family atmosphere, while he revealed in himself a narrow class consciousness. He was a would-be martinet.

Mrs. N. seemed apathetic, but was obsessively houseproud, with a drive to perfection. She was not, herself, greatly worried about Roger.

The only feature of note about his early childhood was his slight discontent. His mother, feeling that he did not thrive, repeatedly sent him to stay with her sister because of 'the dark rings under his eyes', and then criticized her sister for 'spoiling' him.

Roger attended an infants' school for one year; then a private preparatory school where he did badly; thence to a junior school, where he was so difficult that at the age of 8½ he was sent to a boarding school. He was very unhappy and wrote every week asking to leave; he pilfered and the school was glad to see him go after 7 terms.

His older brother was slow and disappointing to his ambitious father and had to go to a crammer's; the twins were unexceptional.

Mrs. N. said that the father had been critical of Roger's untidy and careless ways from early childhood. Roger had never succeeded in pleasing his father and their relationship had degenerated into a resentful stalemate.

Mr. N. said that Roger's behaviour spoiled the family life and engendered an atmosphere of hate. The following incident was typical of Roger's 'defiance': they were to go to tea with their grandmother who lived 10 miles away. Mrs. N. collected the other three but Roger was found sitting in the car dressed only in shorts and 'obviously unwashed'. He refused to wash, so she turned him out of the car, whereat he said he would see they did not get as far as the grandmother's. Mrs. N. took this threat seriously. She locked the house, and though he lay across the bonnet and begged to be taken, drove off without him. When Mr. N. got home at 7.30, Roger had not come home and was thought to be down by the railway with some boys. The paying guests, living with the family, found Roger and told him that he was worrying his mother. When Roger came home he infuriated his parents by appearing unconcerned and 'ordering the best food although it was an hour after the family supper-time'. On a caravaning holiday, Mr. N. had distributed jobs like a sergeant major and was amazed that Roger had 'ratted'.

Roger used to go to a local farm where he was made welcome and allowed to help with the animals and drive a tractor. When there had been a lot to do in the garden, Roger was forbidden to go to the farm, but as soon as Mr. N.'s back was turned, had 'sloped off' to the farm. This 'devil-may-care' attitude infuriated Mr. N., who countered by saying Roger's prayers for him in a whisper and so framing them that Roger could say he was sorry.

Examination

Roger appeared tense and depressed, a tall, thin, untidy-looking boy. R.S.B. Form L. IQ 95, with a long scatter related to fluctuating effort. His reading age was nearly

3 years below his mental age. He sounded most discouraged about school. He said that he sometimes wished he was back at boarding school, though he had never really liked being there. He would like to go to 'a farming school', and in talking about his local farm he became animated. Although reserved about his father, he expressed resentment that the latter should give him jobs deliberately to stop him going to the farm.

He sounded almost despairing about his older brother, who shared his father's interest in electricity, which excluded Roger.

Although Mrs. N. seemed apathetic, she felt dimly his unhappiness at school and resented his discontent at home as compared with his vivacity at the farm. Roger was easy at home with her, but his father was very strict with him. She said this uncritically, however, and ascribed Roger's troubles to jealousy of his brother.

Mr. N. was earnest, but quite baffled by events. Roger was a problem but the older one was so slow and dull that, though trouble free, he gave little satisfaction either. The twins were different.

Comment

Only the self sufficient twins had escaped from the weight of misery oppressing this family. They were thoroughly well-meaning, decent, warm, moral people, lacking only in understanding and adaptability.

There was no evidence of difficulty before Roger went to school, but his emotional security at home was not sufficient to prevent breakdown at the private day pre-preparatory school, where nearly all the children were more intelligent than he.

At boarding school his inadequate intelligence combined with his defeatist attitude robbed him of any chance of success, but his social adaptation there developed at the expense of his relations with home. He was annoyed, first, at being sent away to school before his older brother and, later, at having to travel 120 miles compared with his brother's 8. Back at home as a failure, a life of petty restriction, criticism and recrimination sank the morale of all parties to the lowest possible level. His father became jealous of the farm, which was Roger's only solace.

Roger's behaviour was a mixture of poor morale, despair, punishment seeking, guilt and revenge. Mr. N. knew only how to issue petty restrictive orders. Neither he nor Mrs. N. had any insight into the effect of bitter parental disappointment and a feeling of failure upon a child. The home situation seemed beyond repair, and the education authority eventually sent Roger to a residential farm school.

AN IN-TURNING UNHAPPY REACTION

Eileen H. (82) 9 years

Eileen was underweight and in poor health. She seemed miserable, jealous of her 5-year-old twin sisters, discontented, 'playing-up', 'hysterical', and never still. When her mother had a new dress Eileen might say: 'You don't look nice, you needn't think you do'; but she could be loving when alone with her mother. She slept poorly, had walked in her sleep, and had wet her bed intermittently and sometimes wet during the day also.

The H. family lived in a 3-roomed flat. Mr. H. aged 36, was a technical store-keeper, a quiet, placid man devoted to his family and who tried to compensate Eileen for the twins.

Mrs. H. aged 34, was a smart, intelligent-seeming person, apparently warm hearted. She was anxious but did not want to make a fuss unnecessarily. She said that she was often upset and miserable, and wished she were back at work. Both parents had been only children themselves. The twins seemed to be quite self sufficient, and Mrs. H. was positive that Eileen had never shown jealousy.

Eileen was a good, conforming baby, and the first difficulties were some slight retardation in talking and persistent nocturnal enuresis. The twins arrived about the time Eileen started school, which she disliked at first. At 6 she had a series of boils and suffered a nasty fall on her head at a dancing class. She became thin, pale and tired and was once ordered 2 months' rest in bed. She was cleared of a suspicion of tuberculosis. She had always eaten well.

She was a plodder and a worrier at school; very keen to go to grammar school.

Mrs. H. said: 'She closes up like a clam', that she preferred grown-ups to children but was popular with the latter. She was reliable with the twins and trustworthy with money. She would never play for long. She was fussy and particular about clothes and things in general. Her very occasional tempers took the form of uncontrolled sobbing; she was not sulky.

Examination

R.S.B. Form L. IQ 104; her unusually slow reactions seemed related to inhibition. She was a pleasant looking child with a slow manner, and quickly became friendly under her inhibited exterior. She talked happily about her school. She said that twins were not a good thing in the family, because the others felt out of things. Her ambition was to be a hairdresser. She elected to paint, and slowly and obsessively completed a house. The mother's only notable contribution at this time was: 'If you could only find a bridge; you just can't get to her.'

Comment

Perhaps Mrs. H. made rather too much of Eileen's withdrawal. Eileen's bed-wetting suggested that her security in infancy had not been of a high order. She broke down under the dual strain of twin siblings and school attendance, into psychosomatic withdrawal and ill health. Wise handling had brought about a reasonable adjustment, but the overall in-turning reaction persisted and had baffled her not intuitive mother. 'Latency' fantasy had tended to increase Eileen's withdrawal and her obsessions had augmented her inhibition. However, her over-control was subject to the usual breakdown under stress into panic rages, which she was able to express only within the confidence of the home. She was both nasty and loving (placatory) to her mother, and when things became unbearable, sobbed uncontrolledly.

Rehousing was sought and psychological treatment started, but after two attendances the mother announced that treatment was unnecessary, no more bed-wetting, nor tempers. She was probably right, for all that this family needed was an opportunity to look at themselves in order to gain a deeper understanding.

SEVERE PSYCHOSOMATIC REACTION

Clive V. (83) 13 years

Clive had suffered from recurrent attacks of sickness on the way to school, faintness

at the sight of blood and various phobias, from the age of $6\frac{1}{2}$. Attacks came in bouts of a few days' duration every few weeks, and often coincided with return to school after the holidays. Apparently his ill appearance was not always convincing, because he was given to remark: 'I'm ill, but no one believes it.' He was not subject to digestive upsets nor was he travel sick.

Clive was an only child and the family lived comfortably in a suburban villa. The father was a store departmental manager, a devoted husband and father whose family skeleton was his mother's suicide before Clive was born. Mrs. V. had had so much medical treatment following Clive's birth that Mr. V. had refused to contemplate increasing the family. This was the only strain in an otherwise happy marriage. The maternal grandmother thought that Mrs. V. was unsympathetic about Clive's troubles, but Mrs. V. explained that she wished to give him more active help than 'mere sympathy'.

Clive was easy and placid up to the time of going to nursery school at 3. There he 'seemed to change and he developed quite a little "paddy"'. School reports were glowing. The first upset followed a sharp attack of measles at $6\frac{1}{2}$. He became difficult about going to school; one day he ran home and once, at school, he was smacked for spitting and retching. An aunt remarked that he seemed to be getting younger, going back to baby speech and to old playthings.

He changed school at 8, and 9, and entered a well-known day school at $11\frac{1}{2}$, where he did well. At 11.9 years he had 'inflammation of the liver' followed by 'streptococcal infection of the sinuses, nose, eyes and base of the brain'. He was very ill but made a complete recovery.

Mrs. V. thought him a quiet studious boy who disliked boisterousness. His few friends usually appeared to his parents to be not very bright. With a friend at home they were 'like a couple of old men'. He liked painting and painted a series of pictures depicting fire. 'He won't be told but he does learn by his mistakes.' She wanted him to continue with water colours, but he had 'insisted' on trying oils. He was imaginative and at the age of 9 had worried about death.

His parents cultivated the Arts and took Clive to Shakespeare's plays, concerts, etc. He enjoyed visits with his parents to the Science Museum. He passionately desired a bicycle, but his mother, on principle, made him do odd jobs at 2s. per hour in order to pay for it. He was excited and usually sick before any major event.

Examination

Clive was pleasant, friendly, even vivacious. He showed excellent attention and concentration, accurate self-criticism and perseverance in difficulty.

R.S.B. Form L. C.A. 12.10; M.A. 15.6; IQ 121. Burt's Graded Word Recognition M.A. 13.6.

He was rather girlish in appearance, sexually immature for 13 years and talked in a high flutey voice. His manners were excellent. He described in great detail the boil in his nose, which had affected his eye and the base of his brain. Since then he had been very much better.

He said that he had hated school, at first; but now liked it. He was quite keen on tennis, he said, but disliked football. He made friends but had no one to play with during the holidays. He had enjoyed foreign holidays with his parents and wanted to become an explorer.

Mrs. V. seemed severe, but it was clear that Clive was the centre of the universe for both parents. During the previous 7 years Clive had had four dramatic illnesses, mainly consisting of vomiting, of which the 'inflammation of the liver' and the 'infection of the base of the brain' were the last two. Innumerable other attacks of minor vomiting had accompanied his leaving his home. While convalescing from his liver trouble, he had been sick each time he had attempted to go out into the street, nevertheless he had dug a 5-foot hole in the garden. After the brain infection vomiting delayed his return to school on 5 successive days.

Mrs. V. thought that Clive was very affectionate but needed a great deal of love and morale boosting. Mr. V. was worried because Clive hated losing and loathed competitive sports and games.

Comment

The outstanding feature of Clive's case was his psychosomatic instability. He was the only son of too-careful parents, perhaps over-good as a toddler, and the emergence of his 'paddy' at the nursery school had surprised his mother. Clive had high standards of behaviour and adapted only indifferently well to change. He developed anxiety in competitive situations and automatically vomited when apprehensive.

Almost certainly the condition of cyclical vomiting (see also *Stephen N.* (76) and *Colin Smith* (88)) would account mainly for his major attacks. Phenobarbitone kept these at bay and almost abolished the minor vomiting too.

His improvement may have been due to the coincidence of a frightening infection with a major vomiting attack, which supplied him with a reason for his infirmity that satisfied his own high standards. An increasing measure of success at his school, of which he was proud, also promoted the resolution of his difficulties. His parents' unwisdom in handling him was in a vicious circle with his psycho-sexual retardation of development. He was poor with his own age group, and came to grief when he entered school.

PART VII

Adolescence

Chapter 15

The Main Psychological Features of Adolescence

So much has been written about the psychology of adolescence that in this volume it will suffice to discuss the important areas of stress in the individual and group relationships of this period. Cultural factors are particularly important to consider because the late adolescent is exposed to the full influence of cultural attitudes, with little or no family mediation.

Adolescence is usually taken to extend from puberty to adult maturity but neither boundary is fixed. Puberty in boys will be signalized physically by the appearance of spermatozoa, preceded by some months by enlargement of testes and penis, growth of the beard, axillary and pubic hair, and breaking of the voice. These developments vary greatly in rate of onset, and in Great Britain will normally occur during the fourteenth or fifteenth year. Puberty is uncommon before 12 and late if not there by 15. Among girls, puberty will be signalized physically by menstruation, preceded by some months and commonly by more than one year by enlargement of the genitalia and the deposition of fat on the breasts and hips. In general, puberty appears earlier among girls than among boys; perhaps most commonly around the thirteenth birthday, though appearance of menstruation before the eleventh birthday occasions no surprise. Failure to establish regular menstruation by 15 is not alarming, though when combined with absence of secondary sexual developments would be a matter for possible investigation.

Neither ovulation, which menstruation may indicate, nor spermatogenesis constitute physical maturity. There are many contemporaneous skeletal and other bodily developments that will continue into the early twenties and it is impossible, of course, to establish a critical point of maturation of the body. If the essence of adolescence is the completion of the reproduction cycle, then it could be argued that maturity is reached as soon as the individual is capable of procreation. Such a criterion will mean little, except for one very important bodily implication. Unless there is evidence to the contrary it might be assumed that the individual who is capable of effecting reproduction will be equipped with the appropriate instinctual drives, in terms of bodily desire and erotic concomitants. How will the tension arising be discharged?

To answer this question we must consider the psychological side. Not even an approximate time can be fixed for the appearance of psychological puberty. In the case of both sexes the slowed tempo of psychological sexual

development of 'latency' will show signs of commotion from the age of about 11 onwards. To generalize broadly, girls will show an increase of interest in and awareness of sex, often in a maternal form. The pre-adolescent girl may become an enthusiastic 'little mother' to any available baby, or evince more generally protective and mothering propensities. Less commonly she will become interested in boys or coquettish towards the male sex; equally, however, she may appear to repudiate sexuality and behave as though boys did not exist. The girl whose personal identification before puberty is masculine rather than feminine (see also Chapter 12) may require the impetus of feminine hormones to help her take up a feminine role.

The reaction of boys is perhaps less complicated, immediately before puberty. The standard pattern is a repudiation or repression of sexuality, they 'have no use for' girls. They tend to form compact groups from which girls are excluded except, occasionally, for a 'tomboy' girl. These groups are distinctly anti-feminine rather than merely pro-masculine; and may hold the allegiance of some of the boys until long after puberty.

In the case of both boys and girls, the small friendly group of 'latency' is rather impersonal and usually does not have the exclusive mutual interdependence of some adolescent love relationships. The direct sexual drives of 'latency' can usually easily be contained by the processes of instinct modification, reaction formation and sublimation that were worked out in earlier childhood.

The hormones of puberty create direct sexual drives of vastly greater strength than the child has experienced before. These are in two main directions: emotional, in terms of mate seeking; and physical, in terms of bodily function. The child's emotional relationships take on a more individual character, but opportunity and familiarity almost inevitably guide these stronger drives towards others of the same sex, at first. Children appear to find a mirror of the personality in homosexual friendship. At the same time and especially in the case of boys, gangs of a more rigid structure will form. The maternal drives of girls are stronger and appear earlier than the paternal drives of boys. Girls are commonly ready for heterosexual emotional relationships before the boys of the same age; a fact that society has recognized by greater social protection of girls.

Girls' bodily sexual drives are more directly biological. No menstruating girl can entirely escape the implication of her developing sexuality. The monthly experience of pelvic congestion and flow will impart a certain rhythm of tension and discharge that may satisfy her direct sexual needs, at least for a time. The concealment and protection of her sexual organs, both anatomically and by taboo, may restrain erotic pressures, possibly for years.

Boys, on the other hand, have no such inescapable introduction to adult sex life. Sex might remain highly theoretical, even abstract, for boys, were it not for the exposure to erotic stimulation of their sex organs. The eroticism

of boys may become divorced from its biological consequences and the resolution of conscious sexual tensions will tend to follow the pattern of each boy's previously acquired pattern of instinct modification, subject, of course, to social and cultural pressures.

The erotic component of sex may lead boys to masturbation, which most boys discover around the age of puberty. For a minority, masturbation may develop into a serious moral problem, especially when strong repressive religious or social forces are involved. Masturbation during adolescence is far less common among girls, whose less erotic but more biological sexual urges will commonly find adequate satisfaction in their normal adolescent preparations for home making and in the emotional explorations of the earlier phases of mating. The more direct erotic tensions of boys seek relief, for which the social satisfactions of 'latency' are generally insufficient. However, the great majority of boys will find that instinct modification patterns or sublimations that proved adequate during 'latency' will support them during adolescence also, without unbearable strain.

A minority of both sexes will enter into homosexual love relationships with or without physical sexual gratification. To those of normal psychosexual development these will be unsatisfying and the phase will pass quickly, but when an Œdipus situation resolution has resulted in an abnormal prototype of love relationship, homosexual love relationships may persist into adult life (see also Chapter 12).

Some boys whose instinct modification patterns are unsatisfactory will have recourse to solitary masturbation, with fantasies of heterosexual love. This practice may cause unhappiness and worry through conflict with super-ego ideals. Masturbation as a simple erotic gratification with little fantasy or emotional component is of more serious significance, for it may represent a very regressed attitude, reminiscent of the infant whose direct, self-centered and immediate gratification of a need is the order of the day.

Another hazard of masturbation is that, necessarily, the satisfaction it affords is inadequate. The cardinal feature of healthy instinctual modification is that the modified satisfaction gained is reached with the collaboration of a second party, which enhances the love relationship between the two. Masturbation can increase only self love and, if it is a substitute for normal sex relations, will deprive the self of the ego-strengthening effects of being loved by another. Thus the love-relationship formation of the adolescent will be hindered by masturbation and his psychosexual needs will remain unsatisfied. An unsatisfied tendency will persevere, so that the solitary adolescent may develop a compulsion to repeat the activity, and thus may establish a vicious circle. Guilt over masturbation will increase the love needs of the individual, drive him towards erotic self-compensation, relatively decrease his ego-strength, and thus not only increase his compulsion to masturbate, but also reduce his will to 'resist temptation'. At this stage in the history of the

neurotic, compulsive masturbator, society will often intervene with a harsh super-ego repressive measures, both religious and secular, usually with sad results. It is popularly supposed that excessive masturbation will cause madness, a fear which may scourge the frightened adolescent. The case of Herbert F. (87) shows that popular fear may put the cart before the horse. Though the disorders which cause excessive masturbation may also presage schizophrenia, there is little evidence of direct cause and effect.

THE ADOLESCENT 'PROBLEM'

The very widely differing rates of bodily, psychological and social maturation are a main source of strain during adolescence. The boy or girl, who may be capable of procreation at the age of 14 or 15, cannot normally sustain the stable, adult love relationship necessary for family life and parenthood. Society doubts the fitness of girls for parenthood before about 19 years of age, and of boys before the middle twenties.

In many primitive societies the initiation ceremonies of puberty will lead to full adulthood by a graduated and well-recognized pattern of development. In a static and agrarian society (see also Part I) although the gap between bodily and social maturity may be wide, again, the normal pattern of development is well recognized in the society. In a modern, changing, technological society the situation of the adolescent is altogether more confused. As far as a totalitarian society is concerned, every adolescent is faced with a simple choice—of belonging or not belonging—and individual adjustment difficulties may be driven underground. In the 'multiple choice' societies of rapidly changing Western Europe and North America, most of the British Commonwealth, and of some South American countries, however, the existence of an 'adolescent problem' is generally recognized. The more diverse the society and the more rapid the pace of change, the greater the problem, and it is perhaps nowhere greater than in the U.S.A.

Adolescent difficulties tend to be most intense among the youth in higher education and in technological training, who are suffering an artificial prolongation of the social disabilities of adolescence often well into the twenties. In general they include the healthiest and most robust members of the population, of whom society will later require the greatest psychological maturity and the heaviest bearing of responsibility. Socially, they are kept dependent and irresponsible for, perhaps, ten years after procreation has become possible for them. It is small wonder that strains will occur.

The outcome will depend upon the patterns of instinct modification that are characteristic of the individual and of his society. To the student group the way ahead is plain, their processes of sublimation are sound and their rewards and satisfactions relatively abstract. Though unruly and iconoclastic behaviour will occasionally provoke nervous magisterial comment, students rarely disturb politically stable societies. Among individual adolescents, old,

hidden, but incompletely resolved conflicts, particularly of the Œdipus period, will tend to reappear. Old patterns of son-father and daughter-mother conflict may be revived and aggravated by the wide discrepancies in physical, psychological and social status, of the age.

The teen-age gang is a phenomenon of adolescence that deserves more notice. In British society the gang is predominantly a masculine phenomenon, and it represents the last stage of sexual maturation before the development of individual heterosexual love relationships. Shortly after puberty, boys will form gangs of rigid and limited organization, in which each member has an understood role. Whether these gangs will be antisocial in behaviour will depend upon the leadership, which will, in its turn, reflect collective instinct modification patterns. The group fellowship will be a sufficient substitute for individual relationships in meeting sexual needs and, although homosexual in spirit, the gang will rarely tolerate individual homosexual love practices. Commonly a gang of a dozen or twenty boys will include two or three girls among their members. The girls may be rather masculine, but will bring a slight air of femininity to the group. They appear to introduce heterosexuality to the boys in doses that the latter can tolerate, collectively rather than individually. When, later, individual ties form between the girls and the most mature members of the gang, they pair off and leave the gang.

In addition to the danger of neurotic or antisocial leadership, there is a risk that as the maturing members leave the gang, the leadership will be left in the hands of psychosexually immature members.

The most publicized teen-age trouble of the mid-twentieth century in Great Britain is that of the 'teddy boys'; who form part of an endemic phenomenon of most countries of Western Europe and North America, in times of social upheaval. The peculiar characteristics of teddy boy behaviour were met with, for example, in Czecho-Slovakia immediately after the 1914-18 war, when adolescent gangs wore western cowboy garb; and in Germany during the early 1920's, called 'Edelweiss' gangs. Following the depression of the 1930's the 'zoot-suiters' of the U.S.A. derived their name from their peculiar uniform.

In Great Britain, peculiarities of teen-age gang dress and conduct caused concern during the 1930's in down-town areas of big cities. The appearance of teddy boys after the 1939-45 war shocked many people and has been regarded as evidence of the decadence and perversity of modern British youth. Their name comes from a fancied resemblance of their uniform to the clothes of the dandy of the 'Edwardian' era (the first decade of the twentieth century). Other countries have different forms—in Denmark they are 'leather jackets'—but each uniform is characteristic of the movement, and its wearing is *de rigueur*.

The appearance of teddy boys suggests a neurotic preoccupation with masculinity; the haircut is characteristic, cut long and carefully dressed with

a feminine type of concern for appearance. Shoulders are padded, the jacket lengthened and trousers made tight, so that the lower half of the body is inconspicuous and unimpressive. The teddy girls play an important subsidiary role in these gangs. Their haircut is more masculine than that of the boys, and their clothes generally minimize femininity, except for an almost aggressive, perhaps 'phallic', accentuation of the breasts.

Teddy boys and girls appear to signify a protest of youth against lack of status. They come from among the socially less privileged and educationally inferior. They have recently lost the special privileges of school children, but are not yet recognized by the community as people in their own right. They are mainly in 'blind alley' employment, or in jobs with a low level of technical aspiration; and they have not enough that is worth while to wait for to enable them to bear patiently the apprenticeship phase of life. Therefore, their collective activities tend to be rebellious and directed against authority. They also may have a neurotic urge to prove themselves, and hence are liable to commit acts of motiveless destructiveness, and sometimes both to inflict hurt and to show that they can bear it themselves.

The problem of teddy boys is not very serious, and the way to solve it would appear to be to make the path towards the attainment of full adult responsibility more obvious to them, and to make their learning period more worthwhile by raising the levels of technical aspiration.

ADOLESCENT SEXUAL MORES

In a constantly changing society, adolescents largely lack the protection of a rigid code of behaviour during the formation of heterosexual personal relationships. In the U.S.A. 'dating' and 'petting' practices represent a remarkable spontaneous organization of adolescent codes of behaviour. Although something of this is spreading to Great Britain there is nothing quite comparable here yet. The moral is obvious: that the spontaneously appearing group customs of adolescents in rapidly changing societies ought to be viewed by elders with sympathy and understanding. The hallowed and loved customs of a bygone age may not be relevant to a changed era, but if the developmental processes of children have been healthy, their spontaneous evolutions in face of new problems will be healthy too. For adults to view such spontaneous adolescent developments with distrust is to show a lack of confidence in the upbringing that they themselves have given to the children of their generation.

ACUTE SEX ANXIETY

Arthur L. (84) 13.10 years

The school doctor wrote: 'Arthur's mother is very worried about him. She finds him solitary, neurotic and he has commenced to masturbate in the last few weeks. She says he is very worried about the masturbation and also says it is his only pleasure. I fear her anxiety and worry are doing him more harm than good.'

Arthur's secondary modern school headmaster had not found him a problem. He plodded along slowly in a B stream class of his own age. He was neither specially backward nor forward in any subject, and had no interest in technical subjects. His behaviour was good but he was 'lacking in spirit'. He added: 'He is keen on art. He is a member of the Boy Scout troop. His interests need developing.'

Mrs. L. was small, thin, grey-haired and strained. She had a rapid flow of speech and quick movements. She tried to present the problem in an objective and analytical way. She said that Arthur and she had confidence in each other. To her knowledge he had been masturbating for 6 months. The onset was not related to any specific situation. He masturbated mostly at nights and felt exhausted after it, fearing that he might die in his sleep. After masturbating he would call his mother and she would go into his room and talk with him. She worried lest he should commit suicide.

He was very interested in sex. Mrs. L. knew when he had masturbated at school by his pallor and tension. She had been careful not to appear worried when he had first told her. She said that she was thrilled that he was finding pleasure in that way and explained that this would lead later to more adult satisfaction. Arthur had known about sex from an early age.

Mrs. L. said that Arthur was preoccupied by ideas of illness, and complained of various pains, e.g. a feeling that his feet were splitting. She had told him that it was probably kidney trouble and suggested drinking more water. The next day Arthur anxiously enquired whether one died from kidney trouble.

Mrs. L. frequently contrasted Arthur with his brother James, remarking that however hard one tried not to make differences one could not help being aware of them. She felt that the boys were really too good. She hit them once when they had not waited to be fetched from school in the rain, feeling that they had been deliberately naughty. She thought that she nagged too often and also threatened to hit them. During the war she had 'held the reins rather tightly' because she feared that she would never control Arthur and James (2½ years younger) if she did not start young. Before Mr. L. went into the army he told Arthur (aged 6) that he would be the head of the family. Arthur had taken this very seriously.

Mr. L. had had a lonely childhood and had always wanted children of his own. He had held many clerical jobs. Mrs. L. remarked characteristically that Mr. L. had not wanted the second baby because he was out of work at the time, and also because he wanted to be the baby himself for a while. He had felt the wartime separation very much, he had served overseas for 2½ years, and spent 5 more months in a military hospital.

A few days after his return home, Mr. L. broke down and wept because he had missed James's babyhood (3½ to 7). Mrs. L. said that he got on well with very young children but was useless when they were old enough to query anything he said. He was irritated with Arthur because the latter would never go out; Mrs. L. said that he thought the children were naughty, but he did not understand them; he wanted everything 'just so', and they were made to shut doors and keep things tidy.

Mrs. L. was 6 years older than her husband. She had married at 34 and was as delighted as he was disgusted when Arthur was born after 9 months and 2 weeks. She described her own childhood as 'wonderful'—they had had everything they wanted. They were brought up very carefully, and she did not go out with any men until she was 26. Her parents did not believe in careers for women. Her youngest

brother was born when her mother was 50, Mrs. L.'s comment was that her mother was wonderful to have given her such a present.

The maternal grandfather was an eccentric who, in bad fortune, had turned to atheism which he forced upon the family. He would stand in the hall and call on Christ to come down, thus demonstrating that there was no Christ.

Mrs. L. proudly said that her first independent act was to make a date with a coloured man. When she left home she lived with a woman friend and they planned to adopt a child. Six years later she married, instead, and when Arthur was born the woman friend moved in too. Mr. L. was credited with threatening to have no more children until 'that woman' went.

Mrs. L. said of herself: 'I tried to be scientific, because after my upbringing I could only believe in things I could feel and see. I've always loved children and I always try to apply my psychological knowledge—for instance, in helping other mothers so that they could have more time with their children. I've got the reputation among the neighbours of being the best auntie, but I don't pick them up and kiss them, I believe in treating them as persons. I would like to have had a larger family. When the boys are older I would like to do a course in child psychology and work in a nursery.'

She wished it to be known that she had been secretary of a Communist group. Her youngest brother used to give frequent lectures and demonstrations on hypnotism; and worked with the Marriage Guidance Council, which was odd, said Mrs. L., for his own marriage had ended in separation after 9 months. She said that at 14 he used to lend workmates sums of money and charge interest.

Mrs. L. was very sick during pregnancy with Arthur, and believed that this must have had some effect. She could eat only peanuts and dates, was nauseated by smells, especially that of bread or flour. Mr. L. had had to cut his own sandwiches ever since. She had been repulsed by any body contact, especially that of her husband in bed.

Difficult forceps confinement lasting 51 hours: 'Arthur was lazy and would not move.' Birth weight 7 lb. Breast fed 8 months. Mrs. L.'s perfectionism led her to adopt Mothercraft methods. 'It took four people to make him eat from a spoon.' He sucked his thumb for a long time. Mrs. L. was firm in toilet training but did not 'make a fetish' of it; Arthur was clean by 2 but enuretic up to 5, when a well-known doctor told her that the trouble would clear up when Arthur developed wider interests.

Arthur was thoroughly prepared for James's birth, but Mrs. L. was careful not to 'touch the baby' nor talk about him in front of Arthur. He was extremely jealous, however, and when invited to help, would throw water over him or try to smother him in blankets. She took him to the Child Guidance Clinic, but 3 months later she and the children were evacuated for 11 months.

When Arthur was 3.9 years they returned to London. Two months after Mr. L. had joined the army when Arthur was 6, Mrs. L. went into hospital for 4 months with septicæmia; she said that she was unconscious for a long time. The boys lived with their grandmother and two aunts, and were not allowed to visit their mother. 'They treated Arthur like Little Lord Fauntleroy.' The remainder of the wartime period was uneventful. Arthur's only difficulty at school had been backwardness in reading.

Arthur's Personality

Mrs. L. described Arthur as 'an introvert and extremely self-centred'. He was withdrawn, very quiet, and never had tempers which, she felt, might have helped him. He was 'too good' but when they moved to a suburb when he was 11, he went 'mad' for 2 years under the impact of meeting more children. He led a gang and became very naughty. He once cut a girl's lip by throwing a stone, which was quite foreign to his nature. He had no friends and could find nothing to do in the evenings except just sit in his room; he did not read and was not interested in the garden, and played no games. The mother sometimes found love letters that he had written but he never had anything to do with girls. Writing imaginary letters was 'just one of his sex activities'. His parents made him go to Scouts but he did not like going and frequently made excuses—for instance, that he felt unwell after masturbating.

Until the age of 10 Arthur had had nightmares, and at 6 he developed a fear of dying, which persisted for about 2 years. He had seen some gravestones and had demanded an explanation. A doctor had suggested Sunday School and in spite of her scepticism, it seemed to help him. She said that the children were free in matters of belief but that naturally they modelled themselves on her. Arthur took everything his mother told him very seriously. She thought the children were not anxious about the father during the war—they would ask 'hopefully' whether he had died yet. When questioned about 'hopefully', she said that it was casually said.

Arthur and James got on fairly well together, although Arthur was jealous of James's many assets. The latter was different in almost every respect. Even the pregnancy and labour were very easy, 'as easy as eating a dinner'. She was glad to have had the experience without an anaesthetic. James was 'happy-go-lucky', and made innumerable friends.

Arthur's worst fears came at night when after masturbating he would be seized with panic and call for his mother, who would sit on his bed and talk to him for half an hour at a time. He was extremely hypochondriacal and frequently went to the doctor by himself. His mother said 'he dies every half-hour'. He was so suggestible that symptoms would appear in any part of his body. He wept a great deal over his troubles. He was very obedient.

Mrs. L's anxiety to do the correct thing shone through everything she said and did. She was dominant in the home, but she claimed to have a very good relationship with her rather rigid and unhappy husband. She said that children needed love above all, but appeared herself to be quite unspontaneous.

Examination

Arthur was extraordinarily anxious under test, asked many unnecessary questions, and made quick impulsive movements. He felt very guilty about school failure. R.S.B. Form L: IQ 112; Reading Age 8½ years. When asked what he did at home, he said that he knitted but generally did very little. His reasoning ability was good for his life age, and his fear that a problem would be beyond him did not interfere with his making an effort. He seemed pleased with success.

This worried-looking boy had a remarkably dreary appearance. He was tall and thin, with red eyes and a downy, unshaven look. He talked grudgingly at first, but became gradually more communicative. He complained of a terrible feeling of

tiredness; he felt 'all in' but could not get to sleep; had severe headaches; felt bored and tense and did not like reading.

After some hesitation he talked of his main worry, masturbation. At first he said vaguely that he had masturbated occasionally up to a year previously, but since then had only had nocturnal emissions. He could not leave the subject, however, and admitted that he masturbated about once a week, while leaving a strong impression that it happened at least daily and probably more frequently. He masturbated when he had nothing else to do, and said that his fantasies were rather vaguely concerned with girls. Occasionally he would go straight on to a second orgasm, which might take as long as 2 hours. Lying in bed and thinking might set him off and sometimes he hated himself even during the act. He denied all sex experience with other boys—he was entirely solitary. As for girls, he could not get on with girls at all. He ascribed all his pains and troubles to masturbation, and whereas he used to feel no ill effects, now he felt very ill immediately following the act and often thought he was going to die.

Arthur's troubles responded to psychotherapy. At first there were long recitals of hypochondriacal complaints. He was very suggestible: e.g. he heard of poliomyelitis and wondered if he had it. Abreaction about and interpretation of his masturbation required a long time; and it was then a relief to him to talk of other interests. He became keen on cycling and training for sports. He took a part-time job for the Easter and Whitsun school holidays and spontaneously said that he was no longer afraid of life. He still felt guilty about his feelings towards James. If he had been unkind to James, it would be only right if he fell downstairs and broke his ankle. He showed no signs of heterosexual interests at 15 years.

Comment

Mrs. L. interposed herself between the world and her family. Her perfectionism led her to adopt a rigid attitude to child upbringing that resulted in an over-good child who took his responsibility as head of the family seriously at the age of 6. She pressed him to good behaviour and actively hindered him from getting the companionship of other children, and when he went to a London junior school he did not know what to do. Essentially he was a non-mixer.

This case, upon reflexion, impresses as being that of the 'perfect mother'. She had a beautiful dream childhood with a patriarchal father—atheistic and odd, but of great stature in her eyes; and a mother who displayed excessive care of her children.

She married a rather ineffective man; and her extremely sick pregnancy may have been that of a woman fixated on her own father. Perhaps she was motivated to deprive her husband his part in procreation. Perhaps she would have been happier to have a baby by immaculate conception; but she did the next best thing, put her husband out of the picture and repudiated the physical side of childbirth. Evidently that did not satisfy her completely, for with her second child she was more accepting of sexuality than was, perhaps, quite natural to her. Somewhere between these two extremes might be the true woman.

Arthur grew up incompetent in social relationships, over-good, tied to his mother's apron strings—a poor offering to the patriarchal grandfather.

Mrs. L.'s reaction to Arthur's masturbation was extraordinary. Even though agonizingly guilty, very few boys will tell their mothers. This mother, though un-

doubtedly posing, expressed pleasure and said that she was 'thrilled' about this 'sign of his growing up'. When he masturbated at night he called his mother to sit on his bed and talk about it. A more deeply incestuous situation can scarcely be imagined. The weight of the combination of masturbatory guilt with incestuous guilt that Arthur bore at a practically conscious level scarcely bears contemplation.

Though this situation went back to Mrs. L.'s childhood, to Arthur the urgent problem was that his adolescent relationships had deteriorated ominously. After latency with its fairly non-specific sexual love objects, Arthur had arrived at the stage of adolescent love object formation and had become fixated on his mother, physically, and not only as an abstract concept. Mrs. L., though attempting to intellectualize her reaction, apparently reacted genuinely with a 'thrill'—to use her own word. She was father fixated; she had had a homosexual relationship prolonged until after Arthur was born; she had repudiated erotic heterosexuality, but she seemed to get satisfaction for her infantile sexuality by sharing her son's masturbation. This satisfaction was enhanced by being able to comfort her son and so gain compensation for her failure as a mother. She was strongly motivated to maintain the *status quo*.

In the long run therapy was moderately successful. There was an ominous suggestion of schizophrenia in Arthur's dreary physical state, in withdrawn behaviour punctuated by violence and attacks of acute fear. His masturbation had a terrible compulsive and bizarre quality. However, he consciously experienced his guilt, without dissociation, and was sufficiently integrated to function more normally at school.

Arthur's unresolved Oedipus fixation had prevented normal interpersonal and social relationship satisfactions during 'latency'. Puberty had driven him into direct self gratification of sexual impulses because he lacked the capacity for modification and sublimation of sex drives normally acquired during 'latency'. Incest guilt added to his compulsive masturbation a strong component of self punishment.

Fortunately Arthur was sufficiently well integrated to take the strain of beginning treatment and also his mother was able to modify her attitude.

ACUTE GENERALIZED ANXIETY

Sally N. (85) 12 years

Two days before the end of the Christmas term Sally had a sudden attack of screaming while in a bus on the way to school. She had returned home with one of her sisters and some friends, and her mother put her to bed for a week. Two months later Sally still refused to go on a bus and could not be got to school. She was very listless and lacking in energy, merely sat around and read, and was even quieter than her usual quiet self. She was in her first year at a grammar school and had been top of her class. Her headmistress reported that Sally was good, clever, getting on well and appeared to have no troubles. She thought that Sally could easily make up any time lost from school, if she could be helped to get better.

The psychiatric social worker saw Sally alone at home while her mother was at work. She was shy, she stood throughout the interview and did not turn off the radio, but she talked freely and was friendly. She said that her mother was continually nagging, she could not leave anything alone, and though tired and harassed,

was always doing things and could never rest: 'She is not the sort of person to understand or to talk to.' Sally said that 10-year-old Betty was mother's favourite and never did any chores, and Mrs. N. wrongly accused Sally of not doing her share, and so on. She was different from the others, more like her father, who was separated from the family.

Sally said she visited her friend's house and took the dog for a walk in the park in the mornings. She slept well and shared a room with 15-year-old Margaret. She said she was not bored, she liked reading, and did the housework. She was frightened of the traffic, 'the noise seems to get inside me'. She thought she might soon be able to go to school.

Later, the three sisters were seen together, joking and talking about their affairs; they seemed to find their mother restrictive but to know how to manage her.

Mrs. N. was hard, bitter and complaining; she said that she was so much at her wits' end about Sally that even little things would set her off, and the family was rapidly moving towards a crisis. However, she resisted help and reacted to any explanation or suggestion by saying: 'No, it's not that,' or some similar repudiation.

Mrs. N. had been the second of three children and had had a happy childhood, except that she had been compelled to leave her grammar school at 14 owing to poverty. She had met Mr. N. at evening classes, and he had pursued her from the age of 15 onwards, being very possessive and dominating. She married at 21 and continued work until the day before Margaret was born.

The marriage was happy at first but when Margaret was 6 months old Mr. N. was sacked for stealing £125 to repay gambling debts. Later he lost another job. They suffered hardship and Mrs. N. sold the piano to pay for her confinement with Sally. Mr. N. drank heavily but she forgave him. He was called up into the army when Sally was 4 and soon after became 'engaged' to a young girl with whom he spent his leaves. When he was demobilized he wrote to say that he was going to live with his brother as he could not face family life again. This family was then in a bad tangle. For a long time the two younger children were told that their father was still in the forces, but the truth eventually came out. Divorce proceedings were pending.

Mrs. N. worked to supplement her separation allowance, which was paid regularly. Mr. N. visited occasionally and on the last occasion, just before Sally's breakdown, he said he had come to see Sally but she locked herself in the bedroom and refused to see him. Sally was very attached to him.

Mrs. N.'s pregnancy with Sally was normal: the marriage at that time was still worth something. Confinement and early feeding were normal and weaning easy. Development normal, but Mrs. N. thought that Sally was an 'unnaturally quiet and good baby'. When she was 4, Mr. N.'s absence eased the family situation; it probably suited both parties to have a legitimate excuse for not living together.

There seemed to have been no pre-school difficulties. Sally went through infants' school and junior school, and won a grammar school place with ease; but, in retrospect, Mrs. N. thought that Sally had become quieter and, perhaps, lazier and rather dirty in the process. Scenes would blow up over washing and she was rude when crossed.

Examination

Sally refused to leave the house, so eventually a domiciliary visit was arranged. In the presence of the general practitioner, Mrs. N., Margaret and Betty, and with a blaring radio stilled by particular request, Sally was solemnly asked why she had not gone to school. Naturally nothing came out of this, other than a clinical impression that Sally was not psychotic. A sudden attack of screaming in a familiar situation might herald something serious, for Sally had been getting progressively more moody before suddenly having this outburst. Her current state had been in existence for 3 months and was deteriorating.

Sally was composed and answered questions clearly, but only said she was frightened by noise. She agreed that the situation could not last for ever. It was agreed in Sally's presence, that Mrs. N. should bring her to the hospital the following week. The risk had to be taken that Mrs. N. could not allow anyone else to succeed where she had failed. Sally got as far as putting on her coat but refused at the last minute; but her general condition had improved, she had been out several times and was talking of going back to school the next week. She had had a painful menstrual period, several weeks overdue. The original screaming attack had come when she was due for a period which was 3 weeks late. Mrs. N. came alone and said that Sally was very stubborn, like her father. As a baby she was perfectly behaved and never cried. Neighbours said: 'That child is too good to live.' She had grown tremendously fast in the previous year.

The weeks passed with no progress but with much perplexity. Further home visits achieved nothing. At length an ambulance was sent to fetch her—not an agreeable thing to arrange. Sally had shut herself in a lavatory but was brought out by her mother, threatening to be sick. When she arrived at hospital she was genuinely frightened. She was very cold, looked blue and pinched, was trembling and at first was very hostile. She gradually gained confidence and talked fairly freely, and with added resentment, about her home. At first she said she hated her father, but later that she liked him but was angry with him. He had been a rotter, but her mother had not been too clever either. She again described her fear of the noise of traffic, which sounded like roaring inside her and drove her to scream uncontrollably, and spoke this time in such compelling terms that the fear that she might have been hallucinated was temporarily revived.

She went home in the ambulance, now chatting equably, but still ice-cold, and it was arranged that next week a hospital car would call for her and her mother. No car was available, so the doctor went himself, in a taxi. After the excitement of seeing Sally carried out by the ambulance man the previous week, the doctor's arrival in the taxi brought all the neighbours to their action stations. An undeterred Sally was standing by the door with her coat on, and she got into the taxi with no sign of fear.

The interview continued on much the same lines as before. Sally had been feeling much better about the traffic and the noise inside had disappeared. She agreed to test herself out by walking with the doctor along the main road in the rush hour. She returned to the hospital in high spirits, and agreed to go home by bus. Mother and daughter coped with a rush hour queue, boarded a bus and that was the last time we saw Sally. The following Monday, which was the beginning of the summer

term, she went back to school. Six months later Mrs. N. reported that Sally had not missed any more school and was again top of her form. There was no more trouble.

Comment

Quite a high proportion of the sudden dramatic problems of adolescents show a remarkable changeability. The slow, mouldering type of illness is more sinister.

What had happened to Sally? In her hostility to her mother she had apparently blamed her for driving the father away; and then when Mrs. N. lied about his still being in the forces she had lost faith in her mother. In addition, Sally had encountered the sexual implications of the impending divorce, just at the time when she was facing her own adolescent sexuality.

It was clearly not a school problem. Sally's reason for refusing the headmistress's offer to take Sally to school in her car was: 'I should feel such a fool arriving at the school with the headmistress.'

Menstrual irregularity may have been a contributory cause. Her third period had been due at the time of the bus incident and may have caused a certain anxiety and tension. The trigger mechanism of the breakdown may have been the last visit or the father at which he had finally broken with the family.

Sally had borne more than a usual amount of responsibility for herself, but suddenly she collapsed with a dramatic call for help. Margaret had become moody and off her food, and her emotional withdrawal had thrown the brunt of the emotional tension on to Sally who was the least capable of bearing it, partly because she had been growing very fast during the previous 3 months. The physical and emotional strain of lengthening legs and enlarging breasts is considerable. The break with her father, about whom she was ambivalent, sharpened her hostility to her mother. Sally withdrew suddenly from her own responsibilities for conducting her life.

Sally's schizoid nature was shown in that she would only go out alone, with the dog; she cut herself off from everybody except the family; refused to take any responsibility; and figuratively bit any hand that was put out to help. However, her powers of adjustment had been demonstrated by her past successes. She was rather over-good by nature, and this would incline her to be half ready to meet anybody other than her mother who could help her to retrieve a situation which she knew was both wrong and hopeless. Sally lacked strong parental support and was in need of strong action from a father figure to enable her to overcome her own ambivalence, to have an excuse, as it were, for co-operation.

In comparison with Sally, *Arthur L.*'s (84) anxiety was specifically and agonizingly sexual, concerning interpersonal relationships, and was erotic in character. Sally's anxiety was general, more to do with living through early adolescence, and less with loving. Arthur had to have recourse to his mother, Sally withdrew and shut herself away.

Sally's basic relationships were cool, her mother was hard, and her father absent; but her adjustment had carried her very successfully through 'latency'. Apparently, adolescent sex development reactivated a long dormant Electra situation which had resulted in an open break with her loved father. Her mounting tension had become intolerable. She had a rather explosive pattern of tension release. Over-quiet and over-good most of the time, she would on occasion break out into violent rudeness.

The violence of her screaming on the bus had frightened people but, typically of hysteria, the storm left her calm and well-adjusted within her self-imposed restrictions.

It seemed probable that her tendency towards the explosive release of tension would remain though, in spite of first appearances, her underlying personality was well integrated.

SEVERE OBSESSIVE COMPULSIVE NEUROSIS WITH SCHIZOPHRENIC FEATURES

Ruth V. (86) 12.2 years

The V. family lived in a dingy 2-roomed, down-town flat. Since going to her central school two terms earlier Ruth had become nervous, fidgety, restless, and worried excessively. She felt unwell and nervous.

Mr. V. was a technical clerk, a pleasant, friendly but ineffective man, who was baffled by Ruth's troubles and who hoped that things might turn out all right. Mrs. V. gave a dim impression, was tense, inhibited and was not allowing herself to think about Ruth. Later troubles brought out better qualities of understanding and steadiness in both parents than were apparent at first.

There were no difficulties in early childhood except that Ruth refused to sleep on her own and demanded a night-light. Someone had to sit in the room with her until she fell asleep. Mr. V. was away on war service between Ruth's third and eighth birthdays but she was not separated from her mother. At school Ruth had always been shy, and mixed very little with other children, but had done well enough to gain a central school place.

At the age of 12, Ruth was a pale-faced, thin child with a melancholy air. She spoke only in answer to questions and was inhibited. Her intelligence was only slightly above average on test, but she presented no problem at school beyond her increasing timidity, which the teachers ascribed to her age. She was anxious about losing things and about forgetting to do things she had been asked. She felt sick on school mornings and refused breakfast. She made her mother check and recheck the contents of her bag, and her father accompany her to school. She had phobias about the house and the old lady upstairs.

It was concluded that she was inhibited and obsessional, and of distinctly schizoid temperament. She was successfully treated with supportive psychotherapy over 8 months; her troubles receded and she even won a progress prize at school. No more was attempted, because of her parents' rigidity.

At 15 years 10 months Ruth had influenza and bad earache, and failed to return for her last term at school. She returned to the clinic on her own initiative. She was very agitated and withdrawn, hypochondriacal and her inferiority feelings were intense enough to constitute ideas of reference. Apparently the breakdown had been precipitated by the looming prospect of leaving school and starting work.

Her constipation and abdominal pain caused her admission to hospital for appendicectomy. During her stay of 14 days, her first menstrual period occurred. She was a 'perfect patient' but agitatedly refused to go to convalescence. She was demanding, querulous and jealous with her mother.

Upon her return home she felt too weak and ill to get up. Her parents waited 4

weeks, then telephoned the hospital, in a panic, that Ruth was refusing food and was very weak, but sometimes violent and delirious. When seen at home, Ruth looked weak and ill and was remote and withdrawn. She expressed some persecutory ideas that suggested the possibility of hallucinations. The clinical diagnosis rested between acute hysteria and catatonia.

Her previous therapist visited her daily, more to support the mother than to attack the problem directly. Ruth was very disturbed; she had to be fed, turned in bed, and washed. She was resistant and tore her own clothes. She questioned her mother relentlessly and strongly abused her. She explained that if she did not eat she would be ill, and her parents would love her better. She talked endlessly of dying and murderers. 'It would be better if I went to Jesus.'

In spite of appearances she rapidly improved and 3 weeks later went to stay with an aunt in the country. For 5 weeks she put on weight and wrote cheerful letters but she developed a carbuncle on her leg and again became miserable and difficult. She went home to bed, and Mrs. V. blamed a missed menstrual period. Ruth was very regressed in her interests and increasingly querulous and miserable. She attended hospital as an out-patient, but any pressure on her to start work agitated her. Increasing home pressure reactivated her paranoia, she deteriorated rapidly, would neither wash nor eat and finally refused to get up.

She showed terrible compulsive questioning and complaining. She was too ill to work, she said, but her parents wanted the money. They hated her and she hated them; why could she not have died in hospital, because they were happier without her? Could she be the therapist's 'little girl', or go into a convent? She feared people coming after her, murderers concealed in wardrobes, etc. She was fascinated by crime reports and drew pictures of daggers dripping with blood, and so on. She had ideas of reference, and heard the voice of God calling her name. She thought she might see a cross shining in the sky.

Her parents were desperate and Ruth was admitted to a Mental Observation ward, where her acute signs disappeared and she was discharged home on the expiry of a 15-day order. She remained upset, resentful and unco-operative except for maintaining her out-patient attendance as an insurance against return to hospital. She had a terror of work—people would laugh at her, so she could not show any improvement.

She refused at the last moment to sign a voluntary admission form to a mental hospital, but was more co-operative and attended the hospital occupational therapy group for a while.

Four months later she had a bad cold and some earache, refused all solid food, and was aggressive again with her mother. Six weeks later she signed forms for voluntary admission to a mental hospital, only to discharge herself after 14 days. Ten weeks later she was readmitted.

At the hospital, her obsessions predominated. No headway was made with modified insulin coma, electroconvulsive therapy, individual psychotherapy and social therapy. Bilateral leucotomy was performed 12 and 15 months after admission respectively, and she discharged herself one month later, aged 18½. Her old tension had gone, she ate and slept well, enjoyed outings and, though sometimes noisy, was good humoured on the whole. She could neither concentrate nor occupy herself.

She attended a social club fitfully for 2 months, then worked for 6 weeks, but

suddenly walked out, because she was chivvied for slowness. She had a girl friend and began to go out with boys.

Ruth at 19 was pretty but had an expressionless face. She giggled easily, but lacked affect. She could 'not be bothered with things', made casual dates with any boy, and several times stayed out all night, equally casually denying 'improprieties'.

Treatment at an industrial rehabilitation centre enabled her to regain a marginal adjustment. Her shallowness of affect and lack of responsibility strongly suggested an underlying schizophrenia.

Comment

Ruth had been an in-turning girl, timid, clinging and dependent. Her mother was not understanding and inclined to frustrate her unknowingly. Her father's prolonged absence had led to her fixation on her mother. However, her social incapacity did not prevent her gaining a central school place, above her intellectual level. Her marginal adjustment broke down during her second term there, into an obsessive-compulsive anxiety state. This responded to psychotherapy.

Two and a half years later, the close prospect of leaving school and the sexual tensions of her delayed puberty apparently revived her old mother-fixation conflict. She reacted by sharp regression, too serious for mere reassurance. Her acute abdominal illness intervened and it is legitimate to suspect that her illness was an acute conversion episode connected with the pelvic engorgement of her first menstrual period at the age of 16 years. Appendicectomy aggravated her condition. Upon return home after convalescence, Ruth's regression was so violent as to be bizarre.

Her subsequent improvements when conditions suited her level of regression, and relapses at the slightest pressure upon her to start growing up again might have indicated nothing more than the reactive instability of an over-good, inhibited girl with a severe unresolved Electra complex. Her compulsive obsessional state may have been due to her overwhelming anxiety at growing up (see Chapter 11). Her acute regression and deterioration might have indicated the passive defensive part of her reaction; and her paranoia, a more active projection of hostility. Compulsive thoughts and sensory disturbances, including hallucinations, could arise from florid hysteria.

On the other hand, the more personality disintegrating reaction of adolescent schizophrenia could not be excluded. The clinical picture resembled schizophrenia with paranoid, regressive and catatonic features, at times, in varying proportions; and with the conscious anxiety content terrible in its intensity at times, also. The improvement following leucotomy might be ascribed to the lessening of compulsive anxiety; but Ruth's subsequent emotional flatness and moral apathy resembled that of a 'burnt-out' adolescent schizophrenic more than that of a leucotomized obsessive.

The prognosis appeared to be very poor, no better than that of schizophrenia of comparable clinical intensity. It is instructive to compare Ruth with Sally N. (85). The latter was altogether more dramatic and bizarre at first, but Sally's early circumstances were more disturbed. There was far less in Ruth's history to account for her inadequacies of emotional development; and her withdrawal was more intense, more regressing and ultimately more disintegrating than that of Sally, who was able to externalize her troubles after her first phase of petrification. Perhaps whether

Ruth is to be considered as schizophrenic or not depends ultimately upon the concept of schizophrenia.

ACUTE UNREALITY FEELINGS PRODROMAL TO ADOLESCENT SCHIZOPHRENIA

Herbert F. (87) 15.2 years

Six months before referral Herbert had awakened at night and rushed into his parents' bedroom complaining of palpitations and feelings of panic. On the first two occasions he had insisted on going to the hospital casualty department, but on the third night he was pacified by being allowed to get into his mother's bed. The trouble settled down except for recurrent feelings of depersonalization.

Herbert was the second of five siblings. Mr. F. was 50 years old, an engineering works foreman—rather strict and fussy but a good father. Mrs. F. was a cheerful, extraverted Cockney, who worked as a morning cleaner. The family of seven lived in a wretchedly dilapidated, 3-roomed flat.

Herbert's early history apparently included nothing of note. He had left school from next to the top form of a secondary modern school. He was not very masculine, but not so as to attract attention. He had enjoyed art metal work at school. Mrs. F. blamed two accidents for his condition—very mild concussion 3 years previously; and an electric shock 6 months before. His first attack of palpitations came at the end of his last but one school term. Also, according to his parents, he had just learned to 'express' himself, a euphemism for masturbation, about which the parents were very shocked.

Herbert was a big pasty-faced boy with a dreamy expression. He seemed mildly apathetic, with no retardation and little sign of real depression. He talked readily. He complained that at times things felt unreal. His night-time panics had included 'sinking feelings, pains in the back, left shoulder blade and side of chest, and palpitations'. He felt depressed. 'I dunno what it was, it was something on me mind and it stopped me from going anywhere.' 'Sometimes I don't feel the same as I usually do. In the street I sometimes feel as if I was someone else. I just couldn't understand what they was telling me and I couldn't seem to take notice. I felt scared of something; I don't know what it was. Sometimes when I was walking in the street watching my arms swing, I could feel my fingers lift, so I stood still and I felt light as if I could float away.' After leaving school he was better for a while, but one evening after cadet parade he could not get his breath and 'feelings came over me just like an electrical shock and I felt delirious for about an hour'.

He had worked for one week in an electrical shop but there was too much noise; then for 2 weeks as a house painter's mate. Since then he had been unemployed for one month. He said he had many friends and enjoyed his Youth Club and cadets. In saying that he felt self-conscious because he was the only one of his crowd who had no girl friends, he became acutely anxious.

With great difficulty he was helped into an admission that he feared he was going mad. Acutely embarrassed, he blurted out: 'Well, one night you see I tossed off (masturbated) and this was the first time I had ever done it but as soon as I did it I got the pain in my chest.' Later he said that he had masturbated daily for about 2 years up to just before his first panic attack, when a friend had said that masturbation

would send him mad. He maintained that he had stopped, but then revealed that this was not so. His masturbation had always been solitary: 'I have never taken a girl out, I haven't got the guts.'

He said he had no religious guilt about his way of life. He was a Roman Catholic by baptism, but had not been confirmed and did not go to church. He made one curiously suggestive remark: 'I've often thought I wondered if I could hear anyone speaking, but I couldn't.'

First Conclusion

The first conclusion was that Herbert was of distinctly schizoid personality suffering from acute masturbatory guilt causing severe hypochondriacal anxiety. Herbert's sexual anxiety had been triggered off by his inability to face the prospect of leaving school. His friend's scare story happened to fit into his already very great anxiety. However, it is an ironical fact that though there may be no evidence that masturbation or the fear of it happening will drive a boy mad, incipient adolescent schizophrenia may first present in acute sexual fears or compulsive masturbation. At times Herbert's fears were sufficient to impair, seriously, his reality sense. Although his difficulties appeared to be below the threshold of level of disorder amounting to psychosis, yet schizophrenia was more than a remote possibility for the future.

Subsequent History

Herbert improved immediately and strikingly after three sessions of abreaction about his fears. He started work at a sheet metal works. His mother stated at that time that he had always been a 'spotlessly clean boy', in which she took great pride. She felt that he had grown up, physically and mentally, too quickly. He still wanted a night-light and hated both going to bed and getting up. Two months after his first attendance, he enjoyed a week at cadet camp.

Two and a half years later at 17½, Herbert contacted the department spontaneously. He was worried by sinking and unreality feelings whenever he was tired. He still had a night-light and was sometimes afraid to close his eyes, lest he float away. He was worse in company, often felt depressed and was sometimes haunted by a fear of dying.

He was living at home; his work record was poor—he drifted from unskilled to unskilled job about every 3 months. He was taking piano lessons and had daydreams of becoming a successful musician. He denied that he had any guilt about masturbation.

Though closely observed, no evidence of disorder of perception, thought or affect was found; but his adjustment to life was obviously marginal.

For 10 months Herbert attended for psychotherapy which consisted mainly of abreaction, dream interpretation and reassurance. He had much sexual anxiety and dream interpretation and reassurance. His fear that was 'accident prone' to homosexual experiences of a minor nature. His fear that masturbation had ruined his prospects of successful sexual intercourse was augmented by a phimosis which rendered full erection painful. His dreams illustrated castration anxiety.

Treatment helped him to apply himself more seriously to music but he could not find work which interested him: an inability partly due to his lack of trade training, but more to his apparent motivation to choose work in which he had no

chance of success. His gregariousness involved him in gang delinquency and he was upset by being placed on probation.

Herbert was admitted to a Psychiatric Rehabilitation Centre, where apart from his complaints of unreality feelings, no mental disorder was detected. He spoke of a sense of impending violence. He apparently persuaded his doctor that he had avoided National Service by 'playing up' his symptoms; though any experienced military doctor would have rejected him on sight. He tested at low average intelligence. Neither Rorschach Test nor EEG added anything. The diagnosis was 'Unreality in a schizoid youth'.

The phimosis was treated by circumcision, which upset him more than anticipated. During group psychotherapy he revealed some infantile attitudes to his mother, and little else apart from sexual fears. His doctor reported: 'A schizoid adolescent—lost and wandering and aimless in life as he is in the streets—unable to cope with emotional problems and retires to solitude and "bebop".'

Prefrontal leucotomy was then enjoying its first popularity and with this in mind, an exacting programme of further investigations was designed. Herbert said firmly that he would not consider any brain operation, he would rather stay as he was.

It may be coincidental but the next case note written 14 days after the remark about a lost adolescent, was: 'Much depersonalization on Epanutin, etc. To stop this. Still loafing about—no intention of getting down to things. For discharge Wednesday.

'Diagnosis: Psychopathic personality—schizoid delinquent.

'Condition on Discharge: I.S.Q.

'Recommendation: Supervision, support and youth organizations.

'Prognosis: Poor; likely to develop schizophrenia or chronic delinquency.'

The Rehabilitation Centre did Herbert more harm than good. Psychotherapy failed, no attempt was made to give him technical skills to help him earn a living, and he was discharged unsympathetically, apparently because he refused to give up his illness. For some weeks he looked dirty and deteriorated, unable to take an interest in anything, but after 3 months he improved and started working again.

He relapsed after 6 months, because, he said, he met a 'nice girl, the sort you could go steady with' on the very day following his first experience of sexual intercourse with one of his mixed gang. He appeared to be more disordered and more deteriorated. He had much compulsive thinking and feeling, e.g. walking along a girder he fantasied falling and bouncing back again; or an impulse to drive his lorry into a wall. At dances he would experience an impulse to rape his partner 'like an animal there and then on the floor, for a moment you forget what you really are'. Once he had actually tripped his partner and fallen with her, but apologized and carried on dancing.

He ruminated about the 'mysteriousness and nothingness of everything' and had impulses to kill himself. He got neither pleasure nor guilt out of occasional masturbation. He worked intermittently and was obsessed with the petty dishonesties that he encountered.

He had ideas of reference and thought that people were watching him and talking about him. He was aurally hallucinated at times; his affect though depressed was blunted; and he was seen in bizarre attitudes and gestures.

Comment

Thus the long trek towards a diagnosis of schizophrenia ended after 5 years. Even when Herbert was 15, adolescent schizophrenia had been regarded as the most likely eventual diagnosis. Classical *dementia præcox* was a slowly developing and essentially deteriorating process occurring in a schizoid temperament.

Ought the therapeutic services to have prevented this outcome? The aetiology was obscure: the family history was unexceptional, family relationships were reasonably good. The father was rather remote, and the mother rather hard and unfeminine. Herbert's general inhibition of aggressivity had made him passive and over-good as a small boy, and had resulted in the appearance of obsessional tendencies.

It is possible that the sex drives of adolescence disturbed his state of inhibition; and lack of warmth of parental emotional support caused a condition of unstable equilibrium. The prospect of leaving school and going to work caused his first introspective breakdown.

It is a moot point whether Herbert was worse equipped to cope with adult life or with his sex drives, and low standards of family aspiration did not help with either. He left school with no training and no inclinations, and he drifted in and out of blind alley employment, with no prospects. As far as sex was concerned, he suffered greatly from the effects of collective sex guilt, superstitions and horror stories, and had no help from super-ego identifications.

Psychotherapy gave him some relief from his sexual difficulties but did not help him to live as an adult. The Rehabilitation Centre unaccountably failed both to prepare him for work and to help him with his sex drives. Herbert was happy in casual group life and its congeniality gave him a motive for delaying his return to real life. Possibly his supposed schizoid temperament was not so much based upon in-turning and withdrawal as upon inhibition in an essentially out-turning temperament. The latter state would account, equally, for his obsessional cleanliness and over-goodness, and for his easy accessibility.

Theoretically Herbert's problem originated in the Oedipus phase but whether it could have been recognized then and whether treatment might have prevented schizophrenia can be only speculation. The condition was too far advanced at 15 to respond to psychotherapy alone. It must be recognized that the Rehabilitation Centre added to his incapacity by providing a too congenial present; and then, apparently because he refused a brain operation of unproven value, changed the 'diagnosis' from 'a schizoid adolescent—lost and wandering . . .' to 'psychopathic personality—schizoid delinquent'. His subsequent discharge, deteriorated and bereft of hope, was the last straw.

PART VIII

Disorders of Family Relationship

Chapter 16

Some Illustrative Families

To some extent, all child guidance problems are the outcome of disorders of family relationships; but in the majority of the cases discussed hitherto there has been a focus of difficulty in the relationship between individual members of the family group. In the case of other families, the whole atmosphere is disturbed, albeit by psychopathy of one member. Then, it will be likely that all the children may suffer in turn, but the nature of their suffering will be specific to their stage of development and to their temperament.

The following illustrations range from the anxiety of a socially ambitious and 'respectable' middle-class family to the total breakdown of a 'social problem' family. There is no connecting thread; the families illustrate facets of common family troubles.

The problem of the Smith family (88) was mainly that of an anxious driving mother whose husband, goaded into tremendous efforts by his wife's ambition, found escape in absorption in his business, at the expense of a gastric ulcer. The two children had no escape from pressure at home.

In the Brown family (89), the father was malevolent, on the whole, and the mother reacted with driving anxieties. The older boy was seriously handicapped physically, but brilliant mentally and fared better than his younger sister and brother.

In the Jones family (90), well-meaning, but immature parents were overwhelmed by too many tiny children. The twins formed a mutually defensive alliance that seriously impaired their development.

Both Roberts' (91) parents were well intentioned and socially responsible, but the father's sexual difficulties broke up the marriage. The mother could not adequately fill the role of both parents, and the two sons suffered in very different ways.

In contrast, both of the Scott parents (92) were sexually abnormal, the mother being complementary to the father's deviation. Both sons bore the marks of the distorting influences present in this family.

The key to the Evans family (93) difficulties was low intelligence, emotional immaturity and physical inferiority. The cost to the community of the social inefficiency of this family was enormous.

The Green family (94) is a study in social degradation, with some surprising redeeming features, for the children achieved a degree of adjustment and balance that no one would have foretold.

PARENTAL ANXIETY

The Smith Family (88)

The family doctor wrote: 'Jean Smith is presenting some problems both at home and at school. I should be grateful if somebody could help the mother to sort out *her* problems.'

Jean was aged 6, and lived with her father, mother and brother Colin aged 2.10 in a detached suburban villa. Mr. Smith was a substantial business man and there was a resident maid.

Mrs. Smith had four complaints about Jean. These were:

1. Feeding difficulties, and loss of weight.
2. She was unhappy, touchy, easily flying into a rage: 'I hate you all, I hate you all, I'm going away.' She was spiteful to Colin. She was 'deep', 'reserved', 'you can't seem to get through to her'.
3. Night terrors; since a bad fall at the age of 3 she had occasionally awakened screaming, usually after excitement or trouble.
4. 'Undue' affection shown towards babies and small boys, and a compulsion to stroke and hug them.

Mr. Smith was 'a quiet, rather reserved man, maddeningly calm', very fond of the children and helpful at home. Mrs. Smith credited the paternal grandfather with considerable looseness of sexual behaviour and worried lest Jean should 'turn out like him'.

Mrs. Smith dominated the household and made all the decisions. She was very preoccupied with her own intense feelings and thought that her husband did not understand. She emphasized her ignorance upon marriage, and her husband's gentleness then. She claimed not to have understood her first miscarriage.

Jean was much wanted; born after two miscarriages in 10 years. Mrs. Smith was tense and feared childbirth, which turned out to be easy and normal. Breast feeding 7 months; weaning easy.

Jean's troubles started at 15 months after an attack of so-called influenza, when she lost weight, 'nearly had rickets'. She developed asthma and croup and 'nearly died'. Mrs. Smith still thought she was not strong. Eating had been getting more difficult, she was very fussy.

During the flying-bomb period Mrs. Smith and Jean (2½) were evacuated with Jean's aunt, a boy of 18 months and twins of 12 weeks. The aunt had a 'nervous breakdown' and Mrs. Smith became very 'edgy'. Jean took Colin's birth calmly and seemed fond of him.

Jean had difficulties in mixing at school and she only had very limited tolerance for playing with other children. She would not go to other children's houses.

At her first psychological test Jean had a bad cold and looked very tired. R.S.B. Form L. IQ 107. She needed much persuasion and repetition. Her attention was very poor and she showed no persistence in difficulty. This poor result seemed unreliable; but it was not important at that stage to have an estimate. Three years later and after a period of treatment Jean's IQ was 130. Her attitude was friendly, gay and confident.

At examination when she was 6, it was concluded that Jean was in a state of anxiety. It seemed that Mrs. Smith had been intensely anxious about her birth and

could not tolerate baby messiness. Jean became inhibited at the level of weaning and toilet training, and illness and feeding difficulties increased Mrs. Smith's anxiety. Evacuation and Colin's birth added to Jean's apprehensions in approaching school.

Mrs. Smith's vivid sexual anxieties were potentially damaging. She said that at 6 Jean could not stand any demonstration of affection, but as a baby she had loved to have her neck stroked. Lately Jean had asked for this again and would stand still 'with a look of intense satisfaction on her face'. Jean had started stroking Colin, starting at his head, and eventually, said Mrs. Smith, would 'come down to Colin's private parts'. 'It is all bottled up affection which comes out in an intense rush through the senses. She cannot seem to do it naturally.'

Outside the home Jean could neither love nor hate; but she could not control herself at home, where she was tyrannical and domineering and given to temper tantrums.

Jean attended for psychotherapy regularly for 6 months. She was very out-turning. She gradually learnt both to express and control aggression and affection at the hospital, an improvement which carried over into home and school.

Business removed the family from London for 2½ years, and when they returned, Colin was the major problem, though Jean had had some return of her feeling of not being loved.

Colin was said to be a fifth generation hæmophilic. Three years earlier Mrs. Smith had described him as: 'very easy to manage, a happy disposition. He's just like me and quite different from Jean, it's such a comfort to have him there when Jean has been very difficult.' Now, even this mother was forced to perceive that Colin was very babyish for the age of 6½. He was having two or three attacks a month of severe headache, vomiting, constipation and high temperature, lasting for about 4 days and leaving him 'very washed out'.

Colin was seen twice with Jean and they played together with freedom and enjoyment. Colin was very out-turning, retarded emotionally, and with ill-controlled excitability. R.S.B. Form L. IQ 112. He was most difficult to test, being highly distractable and laughingly refused any test of which he was not confident. Owing to his bright manner, probably more was demanded of him than he could give. Retested at 9.9 years, when more passive in his demeanour, his IQ was 111.

It was planned to admit Colin to hospital for full biochemical examination while in the next attack, but no major attack occurred for 6 months. Once an abortive attack caused his removal from the cast of the school play because he complained of 'my pain'. Mrs. Smith wrote: 'Colin now does everything for himself, school work is above average and we only occasionally see the baby ways.'

For a brief period this family flourished, apart from the father's nervous dyspepsia and the mother's gynaecological complaints that she never had treated because she felt indispensable.

After a few months, Jean ran into acute '11+' trouble. Any reader not familiar with British education might pardonably conclude that grammar school selection was a bogey that haunted all middle-class, socially ambitious (upward mobile) families; and as far as London and its suburbs are concerned he would not be far wrong.

Jean attended a private convent school where most of the teachers were nuns. Mrs. Smith subscribed to the common belief that the atmosphere in such places is

kindlier, the teaching better, and the children more genteel than in the state schools, though experience suggests that only the last of these is objectively likely. Jean had been doing well enough for the school to enter her for the 11+ examination a year early. Jean became uneasy and jumpy, and 2 months before the examination again had feeding difficulties, nerviness, bad temper and sleep disturbances. The mother blamed the nuns' lack of understanding, particularly 'the fierce old ogre who's supposed to teach them arithmetic and who terrorizes the children'.

Jean was extremely tense and florid hysteria seemed imminent. Immediate rustication was advised; and a change to a school that would value the individual child more highly than examination successes to be quoted in the prospectus. The education department offered suitable school placement. Mrs. Smith told Jean who 'simply exploded and screamed and raged. I hope never to go through such a weekend again. She seemed so exhausted that on the spur of the moment we decided to try a change of scene.' Mrs. Smith reported that 72 hours at the seaside restored Jean to a serenity unknown for months. She returned to her convent school in a 'B' class, away from the 'ogre' and grammar school entry was deferred for 1 year.

Next, the mother read of a new medical prophet in the north of England who knew everything about hæmophilia. She wrote: 'I could not get anyone to help me here, so I took Colin there and you will understand my joy when I tell you that Colin is quite normal.' The test could have been done in London, had she mentioned the subject, but maybe she needed the experience to convince her.

Colin at 8½ seemed happy in school and Jean had settled well in grammar school. At 9½, Colin was in bad trouble once more. They had moved house again. 'It seems that the change of school and home was too much for him, and he has gone babyish again. He is on the edge of tears all the time and sleeps badly.'

Mrs. Smith was unusually anxious. She had had little sleep for months, she said, and could do nothing right for Colin. He would not play with other boys, he looked and often was ill. He was devastated if his mother was irritable and whereas once placid, he now screamed and yelled if crossed. His 'terrible temper' was making home life a misery. He was 'perfectly O.K.' on Fridays and Saturdays, the last week of term and the first half of the holidays. 'Colin is a sweet little chap otherwise.' Mr. Smith was out at business more than 12 hours a day, 6 days a week, and she felt unsupported. Jean was happy at school and now 'evenly balanced'.

Mrs. Smith talked about one of her sisters who was 'stark, staring mad, she walks about mental'. She seemed normal, except for an obsessional horror of anything touching her skin. She was quite unable to work. At 22 this sister had had 'a sexual fright' (nature unknown) and had never recovered. Her father used to taunt her with her oddness.

Colin at 9½ was well grown and friendly, but his very out-turning temperament masked severe inhibition. He was tense and fidgety underneath a superficial urbanity and he evaded difficult issues; evidently an anxious, over-pressed boy.

As usual, after many complaints Mrs. Smith left feeling better, but 3 months later started another attack of '11+' fever, 15 months before the event, and demanded another intelligence test. Colin had consented to continue attending school only when bribed by the gift of a watch. He had been demoted to a 'B' class, thereby suffering extinction of grammar school hopes, and Mrs. Smith sought an escape from what she felt to be the shame of a secondary modern school.

Her social ambitions lay in the direction of a small public school and she was encouraged in this by the clearing up of his headaches and shivering fits. Unfortunately Colin's level of intelligence would place him at a disadvantage there. Secondly, his school was geared to the '11+' examination consisting of basic tests in English and mathematics and an intelligence test; whereas the public school common entrance examination at 13, includes English, mathematics, French and Latin. Thirdly, and even more important, there was no boarding school tradition in the family. Colin was to be sent away to escape social humiliation and because they thought he would be better away from home; poor reasons, both!

Jean had just won a free place at a well-known girls' boarding school, but she was very much against going, and her disappointed mother had given in; but this increased the pressure on Colin's going. However, Colin was unhappy and doing badly in his junior school; he had no hope of grammar school entrance. It seemed better to remove him from a hopeless situation.

A place was found for Colin at 13½ at a boarding school that combined the social advantages of a public school with a liberal attitude. However, the boarding preparatory school is an important part of the English public school system, if not from 8 which is too young for all but the most stable, at least from 10 or 11. The preparatory school weans children from home under better conditions of care and individual attention than the best public school can offer. The Smith parents could not quite 'go the whole hog', and they moved Colin to a day preparatory school to give him a Common Entrance course. Unfortunately, the London day preparatory school is often merely an examination-cramming place.

Colin 'became more anxious' when told of the decision to send him to boarding school in 3 years' time. Five months later he had a prolonged attack of diarrhoea, but a holiday visit to the proposed boarding school seemed to reassure him. During the next school term his diarrhoea returned, he was admitted to a local hospital for investigation and a diagnosis (if such it can be called) of 'nervous tummy' was made.

Mrs. Smith was in an almost unstoppable spate of talk. Colin was 'dreadfully highly strung'; he could not face any ordeal; he would break down and cry quietly when made to do things or, if pressed, might go into a panic-screaming attack. He was more and more retiring and would not mix. Jean was doing well at her grammar school but was awkward at home and squabbled unceasingly with Colin. The business prospered, but Mr. Smith, we were told, made this an excuse for spending an irreducible minimum of time at home, condemning Mrs. Smith to loneliness and unrelieved responsibility.

Colin was now 11 years old, tall, thin, pale, and strained looking. However, he quickly thawed out and enjoyed chatting about old times. He was frankly worried about boarding school, 2½ years away, but thought it inevitable.

When a child with a long history of chronic tension and anxiety develops bouts of diarrhoea, there is a serious risk of ulcerative colitis developing. It would have been wise to admit him to hospital for investigation, but the merest hint threw Mrs. Smith into a panic. A maintenance dose of phenobarbitone gr. ½ was given morning and evening; phenobarbitone often acts as a specific for alimentary conversion stress phenomena. Boarding school plans were shelved temporarily.

Colin's symptoms miraculously disappeared. Five months later Mrs. Smith returned and blamed an ununderstanding general practitioner for Colin's relapse.

Three months previously he had become morose, inert, off his food and was sleeping badly. The doctor blamed the phenobarbitone, perhaps rightly, and stopped the drug, and Colin's depression disappeared. One week ago, he had had a violent emotional outburst about not making friends and had alarmed his mother by talking about 'seeing things' that were not there. He was rushed to hospital, and Mrs. Smith was reassured. She was really worried about her husband who was having particularly bad burning pains in his stomach.

Peace again for 5 months; then Mrs. Smith telephoned in a panic. Apparently Jean had suffered from pre-menstrual pains for about 2 years, and from cramping pains before going out anywhere. A locum tenens doctor had strongly recommended a course of hypnosis. Mrs. Smith was alarmed, apparently her old sexual fears and fantasies about Jean were revived. Children whose mothers have had sexual worries about them during 'latency' often show attitude difficulties in adolescence. Unfortunately their own special doctor was away, and when he returned 3 months later, the edge had disappeared from the situation. Jean, aged 15.4 was tall and pretty, thin but well developed. Although rather tense, she was gay, lively and confidential, and laughed about her mother's anxiety over her brother and herself. She was rather apprehensive about G.C.E. Ordinary level, then 6 months ahead. Colin was in a quiet phase.

Jean asked many questions about her physiology, and appreciated an advanced level of explanation. Mrs. Smith then joined the party and fussily checked on everything Jean had said, lest she had forgotten something. Jean protested and they bickered unpleasantly in a way that indicated chronic tension between them and much mutual nagging.

Comment

Though the ingredients of this situation were trivial, this family endured much suffering over the years that might, perhaps, have been avoided. Moreover, the Child Guidance Service devoted much time and energy to this family's problems only to achieve a series of palliative effects. Mrs. Smith's anxiety apparently always kept the clinic at arm's length and she could tolerate only very small doses of treatment.

Mrs. Smith saw herself as a protected, innocent girl married to a gentle, retiring man, and as one who had early felt that she had to do the pushing for both. The family was socially mobile upwards, the father having worked his way up from a little general shop to a more 'respectable' class of trade. Their ambitions for a public school for Colin and their disappointment when Jean refused her public school chance were the more acute, because their attitudes, values, way of life and physical appearance were those of a London suburban family of Jewish origin. Their new and strong cultural identification had apparently added to the volume of their anxiety.

Mrs. Smith's two early miscarriages resulted in Jean's upbringing being attended with unusual anxiety, augmented by the mother's obsessional characteristics. There were heart-breaking anxieties over Jean's early infancy. Feeding was so difficult, she 'nearly had rickets', she 'nearly died of asthma', weaning and toilet training were so messy. During evacuation Mrs. Smith had had her sister-in-law incapacitated with 'nerves' and 2 children under 2½ to look after. In addition, she felt that her

husband needed pushing the whole time and that she must take all decisions for the family. The anxious, obsessional, driving maternal pressure generated in this family was very heavy.

Each member of the family reacted characteristically. Mr. Smith withdrew into his successful business activities, where he could express himself. He also internalized his anxiety and aggression, and developed dyspepsia.

Jean showed acute second-year anxiety, in her inhibition of aggressivity (food refusal), regression (babyishness) and tendency to breakdown of control under anxiety (nocturnal asthma). During the oedipal phase she tended to repress the bodily erotic components of her developing sexuality (pleasure in bodily movement, skin sensation, the expression of loving feelings by caresses and so on). She inhibited so strongly that, in spite of her out-turning temperament, her mother thought she was 'deep, reserved'. Jean's capacity for adjustment was good, but unfortunately her rediscovery of the motor and sensory expression of feelings at 6 (stroking her small brother) agonized her mother because of the example of the maternal aunt. Jean became a barometer of her mother's feelings about her, showing stress symptoms when pressure was greatest; miraculously improving when the mother gained reassurance.

It was fortunate that Mrs. Smith could feel intense anxiety about only one child at a time and she was so preoccupied with worry about Jean's early school adjustment that as an infant Colin was 'very easy to manage, a happy disposition'. The blight of maternal anxiety fell on him in 'latency' and he reacted characteristically by cyclical vomiting and its concomitants (see also *Stephen N. (76)*). Colin's difficulties, in fact, were worse than Jean's. His intelligence was not enough for the family's educational ambitions; he was less active than Jean, though equally out-turning. He had a residue of anxiety at an early infantile level that had caused a long-standing retardation of emotional development and, towards the end of 'latency', reappeared in prodromal signs of ulcerative colitis. There was at least a possibility of reactive depression.

Could more have been done to help this family? The obstacles were formidable. Mrs. Smith, though dependent, was very ambivalent about accepting help, she could bear no strong rival influence in her home. The family lived 10 miles from the clinic, more than far enough for the ambivalent! When Jean had been under treatment for about 6 months, the family moved a long distance away; and it was possible that the move was not unconnected with Mrs. Smith's resistance to treatment for her children. Thereafter Mrs. Smith could stand only occasional visits when things were intolerable; and she could not bear the children to have a weekly absence from school, so that further regular treatment was never possible.

Mrs. Smith herself was never accessible for treatment, her projection of anxiety on to her family was too strong to allow her to accept help for herself. Jean came fairly well out of her difficulties; unfortunately there was less reason to be sanguine about Colin.

CHRONIC FAMILY TROUBLES AND A HANDICAPPED BOY

The Brown Family (89)—see also *Brian B. (4)*, p. 63.

Brian at 7½ was undergoing treatment for an athetoid type of mild cerebral palsy

and was thought to have a 'psychological problem'. Mrs. Brown, it was thought, was 'on the verge of a nervous breakdown'.

Mrs. and Mrs. Brown, Brian 7½, Miriam 4½, and Joseph 15 months, lived in an adequate flat. The family was Jewish and Mr. Brown was a rather unsuccessful business man. He appeared at first to be ineffective and selfish, but later was revealed as more malignant, both schizoid and paranoid. He poisoned the family atmosphere.

The mother was an intelligent woman whose considerable personal charm was often obscured by her vehement struggle for her children. Without her struggles they would have been lost indeed; but her thrashing around increased her difficulties in a world that was generally well disposed to help.

Eighteen months previously Brian had had a mastoid operation followed by 3 or 4 months' convalescence, which in turn was followed by a stay at a boarding school temporarily during his mother's third confinement. Upon return Brian was extremely resentful, 'like a little wild animal' and gave them all 'hell'. This behaviour subsided after about a year.

Brian was premature and weighed 4 lb. at birth. He had had much illness and had attended hospital daily for orthopaedic treatment for 3 years. The journey took an hour, so that half of each day was taken up. The younger children were left in the care of a succession of nursemaids, at a time when such help was very difficult to get. The father was unhelpful; out all day, not helping in the home, merely criticizing when he spoke at all and grudging every tiny expenditure. Mr. Brown had been hostile to Brian since he had been a toddler. He had shown some affection to each baby in turn, but became jealous of them as toddlers. Over a period of 8 years he came to the hospital twice, each time merely to justify his own behaviour and to make paranoid accusations against his wife.

It became clear that Mrs. Brown's pressure of anxiety was at least partly a reaction to the lack of love and support which she had every right to expect.

Mrs. Brown said that Brian was an easy, friendly child, but sensitive about his handicap. He was inclined to rash acts to show what he could do; he was gregarious and good natured. He had been fond of Miriam until Joe's birth but had then become irritable with her and sweet with Joe.

There were no educational difficulties at school. Some clumsiness of his right hand had been noticed but not that he was unusually dependent upon his right hand, nor that his writing was painfully slow and became illegible under pressure.

Brian's medical report stated: 'He is a quiet reserved chap, rather overborne, I thought, by his mother. His main physical handicap is in walking. There is considerable internal rotation of the legs at both hip joints with inversion of the left foot at the ankle joint, very marked on weight bearing. There is also marked rotation of the pelvis on the lumbar vertebrae. The gross movements of hands and arms are quite good, but there was some inco-ordination and, perhaps, slight athetosis of the hands and fingers when finer movements were attempted. . . .'

He wore a left below-the-knee leg iron to correct the inversion and to prevent him from going over on to the malleolus. He was also having relaxed finger and wrist exercises, with the intention of teaching him to play the piano and eventually typing. It was also hoped to teach him shorthand.

R.S.B. Form L. C.A. 7.9; M.A. 11.4; IQ 148. His handicaps in movement and interpretation of space-form material suggested brain damage. Speech and enun-

ciation were slow. His friendly and almost permanent grin might have been due to an athetoid rigidity. His mood was, perhaps, slightly hypomanic, he boasted of his capacity to overcome handicaps of which he was painfully aware. His disability was marked in the left leg and arm, slight in the right leg, and in the right hand only affected the finer movements of co-ordination. He used his left hand only for steady-ing things, by anchoring his arm by his body weight and holding by thumb and finger. He covered his left disability by extra use of the right hand.

In spite of ample evidence of the care and interest shown by his doctors, Mrs. Brown was extremely dissatisfied with his treatment. She felt that she had had to fight for everything that had been done for Brian, and that the general standard of care under the National Health Service, especially on the social side, was 'extremely slap-dash'. She was ambitious for Brian to go to a certain school with very strong competition for entry.

Brian did not present a psychiatric problem; on the contrary, he was well adjusted considering the extent of his handicaps. But he was vulnerable because of the strain of compensating for his difficulties. His adjustment had already broken down once under the combined effects of his illness, long absence from home, the birth of another brother, his mother's tension and the effects of the marital warfare.

Although still 3 years in the future, Mrs. Brown was already fussing about his chances in the '11+' examination. As we have seen, many London suburban and especially Jewish families set an extremely high value on grammar school education. Mrs. Brown agitated because his school regarded Brian as only 'good average'. Brian's handicap masked his very high intelligence and he was operating far below his potential. She introduced extra coaching, which made Brian stale, and the bogey of 'laziness' was raised.

At 8½, Brian's headmaster wrote: 'Brian as yet responds to no measure or criterion of work but his own and so is fortunately free of any self-criticism. He gets away with 'murder' at home but yet a mother cannot expect results for her boy's future by leaving him to his own easy going, 'take all day to do nothing' attitude. I don't believe Brian is brilliant, but I see evidence of ability. To forecast 'X' school would be madness because of fierce competition. Brian may win a free place to a State Grammar school if he can develop "a sense of work responsibility".'

Mrs. Brown also brought Miriam to see us at 5½, thinking her highly strung and excitable, 'mad, wild, and potty', mother dependent and painfully shy. Her pregnancy and confinement with Miriam had been 'awful', Brian was not yet walking. She added characteristically: 'I suppose I was resentful that she was normal and my Brian wasn't.'

Miriam was bright (IQ 127) but not as brilliant as Brian. She was gay, but obviously under tension. In playing with a family of dolls, she succeeded in being abusive about all the members of her family, except her mother. It appeared that Miriam's difficulty was her mother's anxiety; she was mislaid between the handicapped Brian and the easy 2-year-old Joe.

In an attempt to co-ordinate treatment and hold Mrs. Brown steady, the psychiatrist acted as an interpreter of maternal anxiety to appropriate agencies and with difficulty created a more favourable atmosphere. Mrs. Brown used the clinic's attempt to mitigate marital difficulties to strengthen her position, so that Mr. Brown became increasingly alienated, mean and persecutory. His hostility at first hurt

Brian, who came to hate him. Mr. Brown ignored Miriam but maintained some relationship with Joe. He had a separate bedroom and took meals on his own. He would sometimes sit silent with the family, watching television. He made Joe share his bedroom when the latter was 6, which Joe rather liked.

Mrs. Brown would have left him but for the fact that the house was his. She blew hot and cold about a divorce; never quite able to start an action. Indeed under English divorce law it was doubtful whether this terrible travesty of marriage and family life could be dissolved.

The attempt to safeguard Brian's education met with success, after a false start. More understanding of Brian's difficulties was obtained at school and the education authority planned to relieve Brian of unendurable emotional stresses at home by sending him away to a suitable boarding school. However, we had underestimated Brian, who passed the entrance examination to the school on which Mrs. Brown had set her heart. Apart from being forgiven nearly illegible writing, Brian won his place on merit, and had no special consideration because of his handicap.

This committed Brian to coping with an extremely competitive London day public school, about an hour's journey, on two buses each way, from his home. Brian became irritable at home, his homework wrecked the family peace and his progress at school was below his potential.

Mrs. Brown fell ill and had a trying gynaecological operation; Mr. Brown had a slight coronary thrombosis and became even more difficult. The home atmosphere deteriorated and Miriam came into the limelight again. She was now 8, and Mrs. Brown's anxieties about the '11+' were mounting. Only a firm restraining hand kept her from overpressing Miriam, who eventually gained a grammar school place.

Shortly after Mrs. Brown's operation, Brian was admitted to hospital as an acute abdominal emergency and a healthy appendix was removed. He made an uninterrupted recovery, except for occasional blackouts or dizzy turns. Two of these seen in hospital were regarded as *petit mal* in view of his known brain damage, but clinically they might have passed as minor hysterical attacks. After 5 terms at his new school Brian was barely keeping abreast of classwork at the cost of everything else in life. At home he was irritable, tormented his mother and teased his brother and sister. His father was treating him remarkably badly.

There was clearly no future in the then current way of life. Brian was ascertained as a handicapped pupil and, with difficulty, placed at a suitable boarding grammar school of high academic standard, but where allowances would be made for his considerable handicap without smothering him with restrictions. It is risky to send a boy to boarding school from a most unsatisfactory home where there was no boarding school tradition but, greatly to the credit of the school, Brian enjoyed it and positively flourished. He became easier to live with during the holidays and far less jealous. With his father he became cautious and reserved and, with great forbearance, avoided trouble.

Mr. Brown behaved incredibly meanly and foolishly. There was a scene over paying for every article of clothing for Brian, he apparently preferred being forced to pay by the local authority rather than get some credit for generous behaviour. He seemed a curiously masochistic person. Mrs. Brown, in contrast, became prouder and prouder of her son but harried the social services to a degree that nearly provoked obstructiveness out of sheer exasperation.

Nothing in this family could develop favourably for long and at about the time that Brian was settling down, Mrs. Brown reappeared, halfway through Miriam's second term at grammar school, with a terrible tale of woe that Miriam was doing so badly that it was only a matter of weeks before she would be turned out. There were terrible fusses over homework, and Miriam was noisy, abusive and rude. The home atmosphere at this time was particularly horrible. Miriam's disturbed reaction was not unhealthy in the circumstances. The school regarded her as inhibited and rather slow but of average academic ability and as correctly placed in a grammar school. Ironically, Mrs. Brown was terrified of going near the school lest she be told to remove Miriam, which was misconstrued by the headmistress as neglect.

Brian's absence eased some of the tension in the home but it threw more strain on Joe who, alone of the family, had a shadow of a good relationship with his father. One year later the pattern was repeated and Mrs. Brown brought Joe, now $7\frac{1}{2}$, to the clinic, with multiple complaints. He was 'so shut away that no one can hurt him or get near him. He doesn't know which way to jump and often feels no one loves him'. 'He doesn't seem to bother at school and is very behind in reading.' His father confused his loyalties and used him as a spy.

Joe's IQ was 113, possibly an underestimate because of his distractability and need to control the test situation. He was a small, good-looking boy, fidgety, passively friendly but distant. He was very out-turning, but seriously inhibited. His insecurity defence mechanisms, if coupled with no more than high average intelligence would be likely to be a potent source of difficulty.

Mrs. Brown had worried because Joe was backward in motor movements and clumsy. His teacher had told this, of all mothers, that she thought he might be spastic! Joe was an extremely hypotonic child with lax ligaments, so that his thumb could touch his forearm. His ungainliness was due to a combination of hypotonia, inhibition and lack of confidence. Mrs. Brown was encouraged to expect a spontaneous tendency to improve.

And so this family went on. Mr. Brown had another slight coronary thrombosis and his subsequent behaviour was so appalling that Mrs. Brown took another half-hearted step towards seeking divorce. The impetus petered out once again, but her health and morale steadily improved, except for transient panics. Brian had gone a long way towards emancipation; he passed his General Certificate of Education at Ordinary and Advanced levels well, and, at the time of going to press, seemed reasonably assured of a good university place. He was a determined character but he also irradiated charm, and amply compensated those who helped him for their trouble. He alone of this family appeared to have the key to success and happiness, in spite of a cruel physical handicap. Miriam was adjusting, too, in her own way; but much of her energy was expended in securing more independence from her mother. She seemed unlikely to realize her full potential in school. Joe's position was distinctly precarious because of his divided loyalties, but even he began to emancipate himself from his father. To his mother's astonishment he, too, gained a grammar school place and this was the occasion of another of her ludicrous little panics lest she had selected the wrong school for him. There was a resilience about this mother and her three children that indicated the underlying soundness and warmth of their interpersonal relationships.

Comment

There was little specifically psychiatric about the needs of these children that care and thoughtfulness on the part of the medical and social services could not have provided; but only the Child Guidance service was in a position to assess the total need of the whole family and to interpret that need to the co-operating social agencies.

It seemed likely that Mr. Brown was a narcissistic character who was broken down by his first-born son's spasticity. He could not escape his feelings and could not but project the blame. The main object of his projection was his wife, who had enough irritating foibles to attract his cruelty. His markedly in-turning temperament and his disaffection left his markedly out-turning wife totally vulnerable. She reacted by a fierce upsurge of maternal feeling and belaboured friend and foe alike. She would have stopped at nothing for Brian's sake, yet she had insight into the damage done by her extravagance of action. Her insight was the main therapeutic lever.

During 9 years' work with this family much skilled personnel time of the clinic, the local education authority and the local health authority was absorbed. In spite of half successes and perplexities few cases are so deeply rewarding. It is probable that no doctor, educationalist or social worker involved with this family, and apart from transient feelings of exasperation that overcame all of us at times, grudged any of the time spent on the Browns. Their need was certainly great, but their capacity to respond to help and to help themselves by their own efforts was not less remarkable.

OVERWHELMED PARENTS

The Jones Family (90)

For 2 years 4-year-old Peter Jones had been getting increasingly difficult, nervous and highly strung. He was a clinging child with a host of fears, e.g. of the dentist, of being alone in the garden, or of certain people. He was anxious about anything unusual, and got worked up in advance about everything; always had to know the whys and wherefores in minute detail. His frequent temper tantrums resulted usually in a smacking, after which he would 'cry for hours and get into an awful state'. 'He's the boss.' He was dictatorial, impatient and demanding, and destructive with toys. He usually took 2 hours to fall asleep and woke at intervals, screaming. Neither parent had had 'a decent night's sleep for 6 weeks'.

A recent family seaside holiday had been a failure. Peter had refused to leave his mother's side. Mrs. Jones was so goaded that she was 'driven to smacking', which she thought was 'not the answer'.

Mr. and Mrs. Jones, Mabel aged 5½ and the twins, Peter and Paul, aged 4.2 years, lived in a semi-detached suburban house. Mr. Jones was 45, a shop manager, not very masculine; himself an only child who was disinclined to mix socially.

Mrs. Jones was 37 but looked older and prematurely middle-aged. She said she was artistic and found that making the children's clothes was soothing. She had married at 32. She had found the twins a great strain and sometimes felt desperately tired. She had lost confidence in handling Peter's anger and asked anxiously: 'Have I failed him in some way, or do I try to please him too much?'

When 7 months pregnant with the twins, Mrs. Jones was admitted to hospital with paroxysmal tachycardia and slight toxæmia. There was nothing special about the confinement. Peter weighed $6\frac{1}{2}$ lb. and Paul $5\frac{1}{2}$ lb. at birth.

Infant feeding was extremely difficult—4-hourly feeds, lasting $1\frac{1}{2}$ hours, 6 times a day for nearly 8 months; part breast and part bottle. Peter was 'highly strung, crying a great deal and sleeping very badly'. Often 'I have had to go home when out shopping because he would scream if I talked to anyone he did not fancy'.

Peter walked at 12 months; Paul at 18 months. Peter talked well at 2; Paul was still unclear at 4. Peter was clean and dry at night by 2; Paul still soiled at 4. Peter abandoned his dummy earlier than Paul but continued to suck his hankie and a small piece of blanket until $3\frac{1}{2}$.

Mrs. Jones said that Peter was very intelligent and engine mad. He used to get very angry with his mother and would say, "I don't love you Mummy", adding with a 'really vicious look in his eye', "You're no good". Though upset whenever Paul was in disgrace he was 'not really affectionate; he wants a lot of hugging but I think this springs from insecurity, not from affection'.

She said that Paul was more girlish than Peter. People made more fuss of friendly Paul who had curly, fair hair.

Peter's test results: Merrill Palmer Scale: C.A. 50 months; M.A. 55 months. R.S.B. Form L. C.A. 4.2; M.A. 4.8; IQ 112. His vocabulary was good and his perception was critical and analytical. His self-reliant behaviour under test contrasted with his clinging to his mother.

At the clinical examination the parents were very hesitant; upon request Mrs. Jones carried Peter into the consulting-room, which badly upset Paul, Mr. Jones vainly tried to stop his screaming until, 10 minutes later, he was fetched by Peter. While alone with his mother and the doctor, Peter ignored the former and engaged in active, entirely unimaginative, non-constructive play in the sand tray, at the level of perhaps, a 3-year-old.

When asked to fetch Paul, Peter went without hesitation. The twins played together at the same level. Paul was more hyperkinetic and excitable than Peter, and made erratic, vigorous and uncontrolled movements. They merely scooped up sand, except for getting a box from a high shelf and filling it with sand. They took no notice when their mother left the room, nor when their father came in, a few minutes later. They were difficult to dislodge from the playroom at the end of the session. Apparently neither child knew how to play.

Both children were out-turning and hyperactive; Peter, the more forward, was, paradoxically, the more inhibited. Mrs. Jones was so desperate that much sought-after vacancies were found at the local nursery school. Later Mrs. Jones telephoned that all-day attendance was too much for them, they had had such little social contact. She could only tolerate mornings. The Education Department then withdrew the vacancies and Mrs. Jones resisted all subsequent suggestions.

Comment

These ineffectual, comparatively elderly parents could not cope with hyperkinetic twins in addition to a toddler. Mrs. Jones's anxiety had been greatly augmented by her admission to hospital for the last 2 months of pregnancy, and the feeding prob-

lem was the last straw. It is too much to spend 9 hours a day for 8 months feeding twins and who can wonder that she failed to give them basic security?

Mrs. Jones lost confidence and smacked and nagged the more forward Peter, though she knew that this was 'not the answer'. He became both more demanding and more inhibited and, by his consequent development of night fears, gave her no respite day or night. Unfortunately, Mr. Jones also failed to provide a firm framework which could be depended upon.

The twins turned to each other for security and confidence; they formed a strong mutual defence pact which excluded adults. Hence they were extremely retarded socially, they could play only at a toddler level, and developed private ways of communicating that retarded their speech development.

Mrs. Jones could not be helped because her reciprocal dependence on the twins made her reject everything that tended towards their emancipation.

FATHER DESERTION

The Roberts Family (91)

The Brown family (89) provided an example of a hidden broken home; the Roberts family, in contrast, had a resoundingly broken home, cruelly, suddenly and irretrievably; but the damage suffered was not worse than that of the Browns.

Mrs. Roberts lived with George, 10; and Henry, 5, in the matrimonial home, with lodgers to eke out the inadequate allowance sent by the father. He had left the family about one year previously and lived in lodgings $\frac{1}{4}$ mile away. Mrs. Roberts's mother and sister and also Mr. Roberts's two sisters lived nearby. The latter were Mrs. Roberts's chief moral supports.

Five months after the father's desertion George developed daily attacks of vomiting with headaches, which were treated as migraine. He improved but was weepy at night-time and babyish. He demanded to have buttons done up and shoes laced, and became increasingly jealous of Henry. He was most upset at the first anniversary of his father's desertion. He suffered from chronic bronchitis and asthma, and had tended to be untruthful and steal little objects. Since the family break-up all these traits had become intensified.

Mr. Roberts was a graduate teacher in a polytechnic. Mrs. Roberts was very feminine, with considerable artistic talent. She realized later that her husband had had great difficulty in sustaining the marriage relationship; and only very rarely desired sexual intercourse. However, she 'fought hard' and conceived George. A few months later Mr. Roberts was called up, so that his capacity as a parent as well as a husband was not put to test. He eventually became a R.A.M.C. nursing orderly, which suited him. Mrs. Roberts became very depressed during evacuation with 2-year-old George, under very trying conditions.

Mr. Roberts was away from home for more than 5 years. Mrs. Roberts again had to 'fight hard' to have Henry, who was 5 months old when Mr. Roberts finally returned. Mrs. Roberts suffered a reaction and went through a period of ill health which lasted about 2 years. This brought out the best in her husband who helped to look after her and kept the children happy; but the more she recovered the more he became irritable and withdrawn.

They planned a family holiday to mark her recovery, but at the last moment he

asked her to let him remain at home. He needed to be alone and thought he would redecorate the house. He escorted them to the holiday cottage. Upon their return they found him gone, the house in disorder, and a note stating that he would pay a regular allowance. He gave his address but said he would prefer not to be contacted. Mr. Roberts's lodgings were on the boys' direct route to school and later when Henry found out, he was most upset and made longer and longer detours to avoid passing the house. The children met him in the street two or three times and he failed to see them, to their great distress. When Mrs. Roberts met him by chance, she always spoke to him and he was polite though reserved.

Mr. Roberts continued to discharge his responsibilities for the children except that of being ordinarily human. He even came to the clinic in a crisis and expressed a genuine regret. Several years later Mrs. Roberts was persuaded, against her real wishes, to divorce him for desertion, and he married a woman who was well beyond child-bearing age.

The most likely explanation of Mr. Roberts's apparently cruel and callous behaviour was that his latent homosexuality was only barely repressed. Mrs. Roberts's normal sexuality fitted her for the role of wife rather than that of mother to him. The war rescued him from his heterosexual responsibilities and as a nursing orderly in a medical unit he was able to express his homosexuality in a socially acceptable form. Upon return home, his wife's illness enabled him to atone for sexual guilt by meeting the family's need, but her recovery left him to face his heterosexual responsibilities once again. He regressed and fled in panic and guilt, trying to make amends by scrupulousness on the material and financial side. His wife's generosity relieved his guilt and enabled him later to marry a safe mother figure.

At 10, George's R.S.B. IQ was 126 + but a long scatter from year 7 to S.A. I, and signs of emotional tension made this seem an underestimate. His reading was hesitant and his spelling shaky, and his position in the lower stream of a junior school betrayed a serious educational problem.

At examination, George was well grown, tall, sturdy but reserved. Though obviously interested in mechanical toys, he preferred to stand close to the interviewer, just touching him, and to talk, mainly about his father. He described how he used to potter about with his father and go on the river with him. He missed him very much and wanted him back. He partially consoled himself with his 5-year-old brother and had friends of his own.

Investigation revealed that underneath George's mourning reaction there was an old-standing insecurity, dating back to his mother's depressive illness when he was about 5. George was in-turning, and had withdrawn much of his effort from the world. Later he had had a strong emotional reaction against school. His stealing was in self-compensation.

His need was urgent and therapy was started at once (see also Chapter 19), together with an attempt to help his mother. George was due to take his '11+', 6 months later and on then current form had no hope, which was a pity.

Therapy brought George a great deal of release. He accepted the therapist as a father figure and developed boyish interests. Four months later his R.S.B. Form L. IQ was 130 +, but his reading age was still nearly 6 years below his mental age. Remedial teaching in reading was successfully added to psychotherapy and it was later arranged to send him to a special boarding grammar school where psycho-

therapy could be continued. First mention of a boarding school provoked a serious regression into baby talk and baby play, but he quickly adjusted to the idea. He went away at 11.4 years and from an emotional point of view the boarding school was a success.

George's problems having been constructively tackled Mrs. Roberts set about rebuilding her own life and undertook a strenuous course in art that enabled her to earn an adequate living, in order not to be dependent for herself on her husband's allowance. But Henry was not thriving. He had too much petticoat government and was babyish and demanding at home and at school where he made no progress. He was brought to hospital for educational advice. At 6.9 years, R.S.B. Form L. IQ 123; W.I.S.C.: IQ 117. Reading age 5.5 years. Good vocabulary but failed consistently on verbal memory tests. He showed much anxiety under test and inhibited effort in difficulty.

Retest at 7.6: R.S.B. IQ 127; good verbal reasoning ability. Reading age 7.2 years; Spelling age 7.5 years. He could not handle the rudiments of number. At 8.2 years: Reading age 8.2 and Spelling age 7.3. Remedial education at the clinic was started.

Henry was barely holding his own in a B class in a junior school, but since his headmistress thought that he was of only average intelligence, she was not perturbed.

After 6 months remedial teaching, Reading age 8.7; Spelling age 8.0; and Arithmetic age 8.0 years. He continued fortnightly and 6 months later was more confident at the clinic, but in danger of demotion to a C class at school, in spite of his superior intelligence.

Mrs. Roberts, preoccupied by her studies, was acutely aware of failing to meet Henry's heavy demands for emotional consolation. He had much minor illness and migraine, usually occurring when she was going out. She had so far lost her poise as to thrash him when he stole from her. Henry returned the punishment with interest with a succession of nocturnal terrors.

Henry was a fat little boy with an out-turning but barely controlled hypomanic reaction pattern. His unresolved oedipal tension after his father's desertion (when he was 3) had been exacerbated by his mother's emotional stress. Mrs. Roberts, encouraged by George's success, thought of sending Henry to boarding school but the first obstacle was Henry's strong regressive tendencies, with ill-controlled aggression and psychosomatic stress symptoms. Moreover, his current rate of progress was far below grammar school status. Henry was transferred to another junior school to get more individual attention. Remedial education was continued and psychotherapy started (see also Chapter 19). Over 2 years Henry gained some measure of control over his turbulent feelings and increased his masculine identification, in which he was greatly helped by George.

It is unusual to combine psychotherapy with remedial education, but George had psychotherapy combined and then replaced by remedial teaching, whereas Henry had the reverse. At 9.10 years Henry's Reading age was 9.6 and Spelling age 8.8 years; encouraging rather than spectacular progress.

At school Henry's attitude to learning became transformed. At home he emancipated slightly, in his headmaster's words, from 'all the mothers that surround him'. He repaid the confidence shown in him by passing the '11+'.

At 11.10 years Henry went to a suitable boarding grammar school. He was apprehensive and disappointed that he could not go to George's school but that would not have been wise. He settled down quickly, being out-turning and friendly, good at games and courageous. People liked him enough to forgive him his shaky spelling. Though usually happy, Henry still resented his father's behaviour; he could not remember him but he was bitterly critical of him.

George's school placement was a continued success, his psychosomatic ailments improved, attacks of asthma and bronchitis became rare. He still withdrew when uncertain and, compared with Henry, had a better intellect but a more neurotic attitude to learning. He also lacked Henry's out-turning joy in activity, but at school was encouraged with his manifold gadgets and hobbies, and long cycle rides. He was given many small responsibilities. He felt important, secure and loved. His reading and spelling were appalling. In his depression following his father's desertion George's verbal learning capacity had become inhibited. The psychologist who had treated him remarked when he was 18: 'I don't think that he is really capable of thought in words.' His extreme paucity of language gave him the quality of a halting Mr. Jingle. His scientific career was jeopardized by his difficulty in passing examinations, but after a prolonged struggle he was well set on his way.

Comment

The sorrows of this high-grade family came from the psychosexual immaturity of the father. He was seriously mother-fixated, and after his father's early death had been the centre of an admiring circle of mother and sisters. One of his first independent acts had been to marry a very feminine girl, the youngest of her family and rather overdependent. His sexual hesitations had not troubled his ingenuous wife and all might have been well but for the war. Call-up was a relief to many sexually immature young husbands and Mr. Roberts flourished in the non-guilty homosexual vocation of nursing orderly. Mrs. Roberts broke down under the strain of being father and mother to her toddler child, but made a painful adjustment. She 'fought for' and obtained her second child, but when Mr. Roberts returned home she collapsed into dependency.

Her illness alleviated her husband's sexual anxiety but when she recovered, the severity of his conflict can be judged by the savagery with which he repressed his paternal feelings and brutally cut himself off. The enormity of his behaviour enabled his wife to realize his instability, but it badly wounded both the boys.

George was damaged at two levels—a second-year insecurity due to his mother's breakdown during evacuation which left him unconfident in body movements and inhibited in motor expression. His temperament was mildly in-turning. His adjustment was reasonably good. The second level of damage was at the 7-year level, when his mother's depression caused him to withdraw. When his father deserted he was too inhibited to express his aggression, and withdrew into solitary mechanical interests. He recoiled neurotically from learning to read and from number. He could not give his mind to learning.

Henry, in contrast, was out-turning, a bouncing india-rubber boy whose regression due to his mother's depression during his early infancy had been partly compensated for by his father's care. Mr. Roberts's desertion resulted in Henry's regression and fixation at an early oedipal level, but his out-turning temperament vividly dis-

played his need to gain infantile satisfactions. George's inhibitions, in contrast, caused him to withdraw and suffer miserably in silence. Henry was able to relapse into baby talk and find words in which to express his rancour about his father. George remained permanently inhibited with words, both written and spoken; Henry largely externalized his troubles; with proper handling they resolved.

It should be added that Mrs. Roberts's childhood had left her insecure and dependent. She reacted to lesser crises by depressive moods and hypochondria, but in serious crises she had a stability that saved her children from complete disaster. She was a gallant person of unsuspected strength.

BAD FAMILY RELATIONSHIPS

The Scott Family (92)

The Scott family consisted of father, mother, 18-year-old Robert who was in the Merchant Navy and 8½-year-old Clarence. They lived in a poorly furnished two bedroomed flat, their first home having been sold up for debt.

The father was never seen, for reasons important to Clarence's maladjustment, so that the account of this family taken from the mother over a period of years must be treated with reservation.

The father was 48 and an unqualified accountant. Apart from an 'erratic temper' he was amiable and gentle, and fond of Clarence. By 'erratic temper' Mrs. Scott meant that he was perverted sexually and would become violent if she did not 'give in to him'. Mrs. Scott was 48, a sociable person who enjoyed factory work, and took an enthusiastic part in sporting and social clubs. She still played netball and badminton with vigour.

Mrs. Scott was handsome and well dressed, quick and responsive in manner, but her ready smile left her eyes untouched. She had a confidential manner and would lean forward with lowered voice, leaving a strong impression from very little substance. She always gave an impression of latent paranoia, of which no evidence was forthcoming in 7 years.

She said that her husband had 'most peculiar sex habits', but though she was willing to talk, became more and more vague as she got into her favourite subject. He had had poliomyelitis as a boy and had some weakness down one side and 'looked like a human skeleton'. He had little desire for normal sexual intercourse and took a long time to arrive at an orgasm, which she found most trying. He sought erotic stimulation from sex play in unusual circumstances; his favourite location was sitting on a kitchen chair. He took a 'disgusting' interest in her underclothes and was always wanting her to undress while he watched and felt her. He wanted her to masturbate herself while he watched, which she found 'degrading'. She hinted darkly that at one time he had wanted rectal intercourse.

She remarked with spirit: 'Why should I like it—I have a perfectly good friend of my own, he's a lovely man.' She said that her husband had encouraged her to take lovers, on condition that she told him of everything that happened. After a few weeks, he would threaten reprisals, but soon encouraged her to take another. She had not sought separation or divorce; 'The trouble is that I've taken money from men and he knows it. I had one gentleman who treated me very well.'

Clarence was admittedly not Mr. Scott's son. Mrs. Scott naïvely stated that if

Clarence went to a boarding school she would go to live with her current lover.

Robert did not come into the case earlier on. When he returned from his National Service his parents had already separated, Mrs. Scott was living with her lover and Clarence was away at school. Robert chose to live with his father and worked, but a bad fall from scaffolding totally incapacitated him, for psychological rather than physical reasons.

At 8½ Clarence was in bad trouble. He was rough and aggressive at school and learning nothing. Because of his stealing Mrs. Scott had taken him to the police station to have him lectured by the sergeant. He was naughty and destructive and 'out of control' at times. He often wet the bed and also his trousers.

Mrs. Scott said there were no early difficulties. He was in a Day Nursery continuously from 5 months and the nurses always complained that he was difficult. He demanded individual attention, 'he always seemed to have a grudge against people'.

She used some remarkably cruel expressions: as a baby he was 'like a cub'. From 18 months, he had to be caned for not eating 'properly'. He was 'like an animal you had to whip', not responsive or willing to learn. She leant forward and emphatically wagged her finger: 'He doesn't seem to know the difference between right and wrong'. 'You need to hold him under strict control.' 'Up to the time he was 5, only a jolly good caning would stop him.'

When he stole he 'never batted an eyelid' at the policeman's warning. He was 'very possessive and must have everything at once'. Some days 'he's an angel'. 'He had to take the can back for what the other children do.'

She thought he was tough but was not quite sure. She administered 'quite severe discipline', which he accepted with difficulty. After a 'frightful row' he was 'good and hard working' for a period. He used to stay out late at night. He liked to sit chatting with both parents but he was very vindictive about his brother. 'He will either make good or end up in Borstal.'

R.S.B. Form L. C.A. 8.9; M.A. 8.2; IQ 93. Burt's Graded Reading Vocabulary Test: 6.7. He was distractable and fidgety, with poor quality verbalization.

Clarence was a tow-headed boy with a fresh complexion and a soft voice. He played quietly and absorbedly, with slow movements, as if in a defensive withdrawal. His play consisted of obsessively arranging and classifying the toys. Later when more talkative he showed more signs of restlessness and anxiety. He talked mainly about the fact that he had to share his parents' bedroom, though Robert's bedroom was usually unoccupied.

Clarence was out-turning but inhibited, and with strong obsessional tendencies. His tension inhibited effort at school and a serious educational problem was developing. He had second-year difficulties in the control and expression of aggression, and a pressing oedipal difficulty. He was strongly mother-fixated, but his mother's hostility and hatred made him very ambivalent in his turn.

At that time neither parent was fit to have charge of a child. Both parents agreed to Clarence's placement in a Residential School for Maladjusted Children; he, because with the impending break-up of the marriage Clarence would be then out of his wife's clutches; and she, because she planned to leave her husband.

Finding a school took 8 months and deterioration in the home atmosphere sent Clarence away in a very disturbed state. He became depressed and was bullied at

first, and it took 2 years of psychiatric treatment at school to stabilize him. Three months after his departure, Mrs. Scott obtained a separation order with custody; and was living in a furnished bed-sitting room with her man friend. She informed the local education authority of the circumstances, in order to justify her inability to have Clarence home for the holidays.

Two years later, Mrs. Scott moved to 2 furnished rooms, still partly supported by Mr. A. who had returned to his wife, but who was a frequent visitor. Clarence started going home for part of the school holidays, and visited his father regularly also. The next hazard was that Clarence at 13 was found to be the centre of a practising homosexual group. Fortunately this was handled constructively. Then he clashed badly with a new master and in the subsequent flare-up his mother went right back, at the moment when she seemed to be stabilizing.

Robert then went to work near Clarence's school, in a short-lived attempt at rehabilitation. Clarence was restless and wanted to join his brother, and then to return home and go to a day school. His mother tried to be severe; but she was changing from the harsh person of former years into an anxious and ineffective fussier. Mr. A. had left her but she would not return to her husband. A sign of her growing stability was that her love-life no longer dominated her conversation. She conceived the romantic notion of moving near the school, taking a job and making a real home for Clarence. The latter was excited and Mrs. Scott got as far as having an interview at a factory; then she produced several unanswerable reasons why she could not move, and the plan collapsed.

This marked a turning point in 14-year-old Clarence's attitude to his mother. He saw through her, and he was strong enough to emancipate himself, though his disturbance was shown by wide swings from maturing conduct to stupid infantility. Good handling at school, psychiatric treatment and the onset of puberty helped him through.

A year later he was seeing his mother clearly, and charitably; he had written off his father and brother, but did not mind seeing them occasionally. He voluntarily decided to remain at school until 16 and then take a technical apprenticeship which would entail living away from his mother. His headmaster wrote: 'One has to remind oneself of what he was when he first came, to see how much better he is, and be thankful.'

Comment

Mr. Scott was a repressed homosexual fetishist with feminine and sado-masochistic tendencies. He provoked his wife into wronging him and then allowed her to 'get away with it'. Mrs. Scott had strong masculine and also sado-masochistic tendencies. She over-compensated by exaggerated heterosexual femininity, and her husband's tantamount female homosexuality was abhorrent to her. Her sadism sought the destruction of those whom she loved, for which her neurotic over-protection of her children was compensation.

Robert's early life pre-dated the full impact of these perversions, and he reacted to family tensions by neurotic anxiety and psychosomatic illness. Clarence suffered, in turn, fixation at the second year, with inhibition and obsessions; and at an œdipal level, with sexual retardation, especially of masculine development. Just as his

mother was not far from prostitution, so Clarence was for a long time in danger of passive inversion.

The social handling of this case might be controversial. Mrs. Scott's openly avowed intention to get Clarence away to school at local authority expense and to live with her lover succeeded perfectly. Should it have been allowed to do so?

The local authority acted in full consciousness of all the implications, preferring to judge the case on the boy's need. Both parents were exerting a pathogenic influence and the coincidence of the right course of action with the mother's selfish and immoral interests was irrelevant. People lacking good will noted that it cost about £2,000 in school fees and maintenance alone to rescue Clarence and bring him to the start of a technical apprenticeship. (It costs very little more to take a student right through a medical course.) However, by their action the authority rescued a boy from certain psychological and moral disaster, and gave him a good opportunity to succeed.

A SOCIAL PROBLEM FAMILY

The Evans Family (93)

The Evans family consisted of the father, mother, Albert aged 8.9, Winnie 7.8, and Elsie 5.10. They lived in 4 wretched attic rooms with no water, sink or w.c.

Mr. Evans was a rough, casual labourer of 36, from a large and quarrelsome family. He had been a heavy drinker before the war, but since demobilization 9 months previously had treated his wife rather better. He was roughly affectionate, but selfish and demanding sexually.

Mrs. Evans aged 27, had 7 siblings; her father had died when she was 6, her mother was hard and unloving and she had grown up in an orphanage. She was ill-prepared for life and married at 18 when pregnant with Albert. She seemed overwhelmed by her difficulties and had never really loved her husband.

Albert had been unwanted but his mother had said: 'Once I had the boy I knew what to live for.' He was breast fed for 3 months, a greedy demanding child, crying day and night. When her second baby arrived 13 months later, Mrs. Evans abandoned all real attempt to control matters, and drifted. Albert had always wetted the bed.

Winnie was born just before the war and Elsie after her father had joined the army. Mrs. Evans was quite good with tiny babies and the years with the father away were relatively satisfactory. The two girls were easy.

At 4 Albert and Winnie went to a residential evacuation nursery for 2 years without seeing their mother. Albert was difficult there and almost unmanageable on his return. At 7.3 Albert had jaundice severely, 'played up the nurses' and was sent home early. At 8 a gangrenous appendix was removed and 6 weeks' convalescence followed. Peculiar habits, 'eating wasps and flies' were reported.

When Mrs. Evans first brought Albert to the clinic she was angry because she was pregnant again. She had trusted her husband to 'withdraw' and she felt so let down that she now represented him as gambling and drinking and doing nothing to help at home. She decided to be difficult on her own account.

Mrs. Evans was changeable about Albert, sometimes identifying him with his father—he was rough and rude, demanded money; was out all day with a gang of

older boys. At other times she related him to herself—he was so thoughtful when she was ill, 'he's got a lot of love in him'. He would help with her home basket-work and she would reciprocate by taking his shoes off or hanging up his coat—for which he would call her 'muggins'.

Albert's attendance at school was most irregular through truancy and much illness; he was making no progress educationally. He was rough, uncouth and quarrelsome, stole small objects and sums of money; and was dirty in his habits.

At 8.9 and 10.2 years, Albert's R.S.B. IQ was estimated at 95 and 87 respectively. At 8.9 years his reading was 2½ years, and number 1½ years retarded. He was a weedy, thin, myopic boy with babyish speech. When his confidence grew he revealed many fears of ghosts and wild animals, rough boys, hard lessons at school and of learning to read. He appeared to test out the doctor by being cheeky and provoking and to prove himself by feats of strength, carrying the furniture about. He also played with dolls in the pretence of showing them to his sister.

It was apparent that Albert's emotional security had been undermined by prolonged separation and he was in a severe state of oedipal fixation. His home was so unpromising that a residential school for maladjusted children was recommended. However, against clinic advice, an open-air Camp school was tried for 3 months and no more was heard of Albert for about 2 years, when the problem appeared worse and the marriage was breaking up. A residential school was recommended again, but before this could be effected, the parents separated under disagreeable circumstances. The children were taken into care, and the Children's Department achieved the triumph of sending the youngest, Jackie, 12 months, to a separate Residential Nursery.

Mrs. Evans had two places to visit on her weekly day off. The matron of Jackie's nursery reported: 'We've never had a baby with such a bad temper.' At 2 he had an emergency mastoid operation and by chance his mother was also in hospital and could not visit him for 3 months. At 3 Jackie joined his siblings and became much happier. At 3½, both parents and children were reunited.

One year later Albert (13.10) was in trouble again. He was very violent: 'Breaks dishes when he's in a temper: shouts and gets so worked up he doesn't know what he's doing; steals food, destructive, breaks up the other children's things.' At psychiatric re-examination he appeared to have deteriorated, he was still wetting his bed and his educational retardation was as much as 5 years. At last he was admitted to a Residential School for maladjusted children, where he remained until 16.

Eight months later Mrs. Evans complained that Jackie (5.2) was demanding and defiant, with frequent temper tantrums and screaming bouts, was rarely asleep before midnight, he could not bear to be parted from his mother. The home atmosphere was made discordant by Mr. Evans's excessive sexual demands on his wife.

Jackie's IQ was 108. He was small, pale-faced, undernourished, underweight, and looked like a 4-year-old. He looked pinched and strained; with backward and lalling speech. His relationship formation had been so sadly retarded and weakened by early separation that he was functioning at a 3-year level. His mother was inclined to demand 6- or 7-year-old behaviour from him and be upset when he did not give it.

When Jackie was 6½, Mrs. Evans obtained a judicial separation on grounds of persistent cruelty, and the father was forced to go at the moment that Albert left

school and returned home. Albert was extremely unsettled at work for a long time.

Although Mrs. Evans's main grounds for separation had been her husband's excessive sexual demands and although she was warm and understanding and the only prop of the family, she greatly contributed to its instability at this time by having a love affair of her own.

When Jackie was 7, Mrs. Evans suddenly went into hospital, Jackie and Elsie (then aged 13 and very backward) went to a residential home for small children.

Jackie deteriorated when he went home to find his father permanently away and Albert being very dependent and unsettled. Jackie was fixated at a pre-œdipal level and was distinctly girlish. He used to wet the bed nightly. At 8½ he went to a boarding school which accepted a few maladjusted children.

The nadir was passed and this family tended towards improvement. Jackie settled passively at school; Mrs. Evans was able to earn more and, with his sisters' help, Jackie's holidays at home became more supportable. Albert was more settled in work, took a girl friend and stopped wetting his bed. Medical examination for military service caused a relapse, which was cured by rejection for service after weeks of misery. Winnie had a boy friend and became difficult at home. The backward Elsie was docile and reliable.

A curious incident illustrated the family level. Mr. Evans visited the children regularly, to his wife's disgust. One day about 2 years after the separation he arrived in a van with his sister and two cousins. The sister said to Mrs. Evans in 14-year-old Elsie's presence: 'If you can't take him back, at least you can let him satisfy himself.' Mrs. Evans commented: 'I thought I was past blushing. I felt terrified and was really glad Elsie was there as it was 4 to 1.' She imagined that she was to be shanghaied into the van. She rushed out and told the Probation Officer.

And so they went on. Albert married at 19; a baby was on the way and they had nothing saved up. Jackie's report after 7 terms was of greater emotional control but strong tendencies towards psychosomatic troubles. Educationally he was very backward indeed and still prone to screaming attacks and bursting into tears. Winnie was quarrelsome and longing to leave home. Only Elsie was subdued. Albert left his wife after a quarrel soon after the baby was born, but returned and they limped along.

It is instructive to estimate the direct financial burden of this family upon the community. Albert and Winnie, 2 years' evacuation *c.* £500; Albert, 6 weeks' convalescence £25; 3 months in a camp school £50; the four children, 2½ years in Care, say £2,000; Albert, 2 years' residential school £800; and Jackie, 7 terms' £900. The total of £4,275 is exclusive of long periods of Public Assistance, and Jackie had in front of him a probable 15 more terms at boarding school, £2,000. The cost of social worker, clinic and local authority time has not been included.

This staggering cost for so little result is partly owing to the unsatisfactory administration of social welfare, which demands that a bad marital situation must become insupportable, in fact irretrievable, before help can be applied. Meanwhile, irremediable damage was done to the characters of two of these children. Mrs. Evans was given insufficient assistance to keep her family together. Only the clinic attempted to help her to live with her difficulties.

The community policy will be rewarded. Already at 20 Albert showed every sign of repeating the pattern of his father's life. This problem will be perpetuated.

The wrong sort of help was given too late to rescue this family from a fate they could neither prevent nor control.

A SOCIAL PROBLEM FAMILY

The Green Family (94)

This family lived in 3 small rooms in a rough, down-town street; they comprised the father, aged 34; mother, 31; Billy, 13; Bert, 12; Ivy, 10; Edie, 9; Arthur, 4; Tommy, 2; and Janey, 6, who lived permanently with an aunt. Furnishings were poor, but the rooms were clean by local standards; the children were well nourished and not badly clothed.

Mr. Green was an engineering fitter. His mother died when he was a baby and he had spent some time in an approved school, and about 8 years previously had served a prison sentence for larceny. Since that time he had 'gone straight'. His great interest in life was cricket. Mrs. Green was one of 14 girls and one boy from a remote country village; she had come to London in domestic service at 15 and had never gone back. She was a short, sturdy woman whose good looks were impaired by continuous child-bearing. She was first seen in bed, after the fourth miscarriage to which she admitted during the last few years.

Billy was a main prop of the home. He was an ingratiating boy, easily upset, and when in trouble a blocking stammer rendered him speechless. He was loyal to his mother though often up against his father. He protected his sisters, to some extent. Bert never got into trouble but had an exceedingly dim school record.

Ivy had had a chequered career. Mrs. Green said she had doted upon Ivy, the eldest girl and a very bonny baby. At 11 months Ivy went to a residential nursery while her mother was confined, and there contracted scarlet fever followed by diphtheria and stayed for 12 months. Ivy was upset following visits and Mrs. Green stopped going. When she returned home her parents thought there had been a mistake in identity, she was so thin, undersized and miserable. At 11 months she had walked and said a few words, but at 1.11 years, she crawled on her bottom, dirtied her pants without asking, and seemed sullen and out of things. With the father in prison, Mrs. Green felt that she had not coped with Ivy very well. Five months later the children were playing with matches and Ivy's apron caught fire. She was terribly burnt and in hospital for 6 months. Ivy ignored her mother's visits. She had a bad residual scar on her neck and chin. When she returned home she was sullen and 'quite out of the family', and never seemed to fit in again. Subsequently she made no progress at school and became exceedingly backward.

Edie was the beauty of the family, and knew it. Poor Ivy was equally pretty but for her disfiguring scar, and was most jealous of her. Edie was her mother's favourite, but others thought that she had a spiteful nature.

Janey had been taken by the father's aunt when quite a small girl and no longer came home for holidays. Arthur and Tommy were healthy and apparently undisturbed by the turmoil that passed for their family life.

Mrs. Green was overburdened by the size of her family. She brooded about Mr. Green's refusal to co-operate in family limitation until she was 'ready to go for him'. He would not let the boys help in the house, in spite of Billy's willingness, and this upset the girls.

At 10½ Ivy was the *casus operandi*: she was said to be a trial at home and at school through arrogance, spitefulness, bad language, trouble making, causing fights and quarrels, lying, sullenness and initiating sex play with smaller boys. She was 'deep', 'can't be got at'. Her parents' long serious talks with her made no difference, and she could rarely accept or give affection.

Ivy was examined; R.S.B. IQ 77; W.I.S.C. Performance IQ 64. She was out-turning but shallow in relationship formation, though not totally devoid of relationship capacity. Her coolness, in combination with her out-turning nature and her need to gain compensation for a drab existence, created a most misleading impression. Her friendliness and pleasant manner concealed her lack of capacity to form attachments.

The most urgent problem was that Mrs. Green was dangerously anæmic; and treatment was instituted. Meanwhile information accumulated about the violent life led by this family. Most of the time they were devoted to each other, with Ivy the odd one out. But they were all involved in constant quarrels, and on several occasions neighbours had sent for the police to caution them. One scene was described, later, by Billy, in a moment of stress. The children had been awakened in the night by the sounds of furious argument and of furniture being upset. They crowded into the living-room to see the father advancing upon the mother, who was armed with the carving knife and shrieking blood-curdling threats. She suddenly threw herself at him and they fell to the floor, wrestling. The scene culminated in sexual intercourse between the parents, after which the whole family repaired to bed with harmony restored. Billy indicated that this had happened several times, and there was no reason to disbelieve him.

Though of primitive emotionality, the bond between these people was very strong. Most of the parents' quarrels were provoked by the father's jealousy of the other ground-floor tenant. Next, Mrs. Green became pregnant again and her health gave acute concern. She was admitted to hospital for termination of pregnancy and sterilization.

The night before the operation, in an emotional moment, the mother revealed that she was not married to Mr. Green. She had become pregnant by him at 17 but she had never trusted him enough to marry him, because he had never even pretended to be faithful to her. She had, however, lived with him for 13 years and borne him 7 children. In earlier years it had been she who had refused marriage but, later, when she asked him to marry her, he preferred to keep the possibility of desertion to enforce her fidelity.

Sterilization was performed, and while she was still in hospital, Mr. Green forged a love letter from the tenant in the next room, giving an accommodation address. She replied and, incredibly, Mr. Green brought the letter to the clinic for advice. A nice problem in marriage guidance! He explained that he had suspected her, and a few days before he had turned back instead of going to work and found her not in. He hammered on the locked door of the next room and had no reply. His conviction that she was inside was supported by a sentence in her illiterate and novelettish letter: 'little did he guess that it was me in bed with you'.

It was interpreted to him that so long as he withheld marriage she would spite him in this and similar ways. He replied that he would be unfaithful to her as long as she was unfaithful to him. And so on. 'Now she's been sterilized there'll be no

holding her', he said. He had temporarily stopped work to look after the children, but he said that as soon as she was well enough to take over, he would clear out for good. He knew a very nice young lady who wanted him to live with her. His least attractive attribute was his self approval.

They had a bad scene, which the mother took meekly; he did not leave and life went smoothly for 3 months. Then Mr. Green persuaded her to return to hospital to have varicose veins removed and, once again, took over the care of the children. He was at his best in such circumstances.

For the next 6 months the family did quite well, except for Ivy who was chronically in trouble. She was sent to a residential school for maladjusted children, where she found moderate happiness for the first time. Mr. Green worked away for a while at a hotel, then he was in hospital and at home for some months with serious eye trouble, and the family atmosphere deteriorated.

Although the old passion had gone, the Green family life was not pleasant. Several times the father left home for a few weeks, but continued to support the family. Then he lived away for several months, visiting occasionally; and turned up on Christmas Day laden with presents.

Fifteen months later Mr. Green was still away, but visiting frequently, being very pleasant and paying regularly. When Ivy was 15, her future was a problem. Her school friends had left and the staff found her trying. She wanted to live near the school and work but the staff could not tolerate the idea. Poor Ivy could not love anyone and no one could love her. Mrs. Green did well enough with the other children but had no use for Ivy. She was placed in lodgings voluntarily under the supervision of the Children's Department, which was the best that could be managed; but the outlook for her future was not hopeful.

Comment

This history suggests that when children have a good capacity for loving relationships, even extremely traumatic experiences in later childhood may have surprisingly little adverse effect. But Ivy's capacity for relationship was weak, so that she was vulnerable. She sought compensation without being able to give love. With her good looks, her needs and her deprivation, it could not be hoped that Ivy could escape a life of sexual irregularity. On the other hand, she was the sole family casualty; and it might be contended that to break up this irregular family even at the depths of their parents' degradation would have done more harm than good to the others.

PART IX

Child Guidance

Chapter 17

The Main Clinical Syndromes

THE next task will be to attempt to relate the clinical phenomena which have been described to a basic system. Up to the present, books on Child Psychiatry¹ have usually employed a classification based entirely on symptoms and signs, and there is nothing more to be learned now from this method of approach.

Instead, we must look for the main groups of symptoms and signs that appear sufficiently commonly in combination to constitute a recognizable pattern of illness or disorder—in other words, a syndrome. The task will be complicated by the dimension of time, in the form of a succession of environmental events to which the child must adapt, and which also influences importantly the internal adaptive processes of the child.

In Chapter 6, attention has been drawn to (1) the 'embryological analogy'; (2) the effects of developmental anomalies; and (3) the effects of the time dimension.

1. All psychological development depends upon the concurrent existence of four factors:

- (a) an inherent predisposition for the specific development concerned;
- (b) a matrix of existing function in the form of perceptual experience, out of which the new development can emerge;
- (c) material out of which the new development can form; i.e. environment experience and tendencies;
- (d) an 'activator'; i.e. the intimate emotional rewards of maternal care that will facilitate instinctual modification and new development.

2. When anomalies occur in the developmental sequence, a number of consequences may follow, among which are the following:

- (a) the development in progress will deviate from the normal path, e.g. a mother-fixated 4-year-old boy may tend towards a feminine style of life;
- (b) the child will react directly to the difficulty; e.g. withdrawal or excessive demand;

¹ For an example of classification by symptom and sign see *Child Psychiatry*, by Leo Kanner, 2nd Edition 1948.

- (c) there will be an environmental counter-reaction, e.g. the mother will become anxious or punitive;
- (d) the immediate next development will be adversely affected, e.g. the child will reject the next learning experience, such as not learning to talk;
- (e) the resulting distortion will affect subsequent developments; e.g. hyperkinesis may make the child impossible to live with.
- (f) the combination of developmental anomaly and environmental reaction may harden into a lasting pattern of deformity, e.g. retardation of development, or overcompensation, or a mixed pattern.

3. Time, as transmitted to the child in the form of cultural expectations, provides a tension in the environment that may stimulate development (an 'activator'); or when excessive or inappropriate may paralyse development. In the latter case the resulting stasis will show up as an increasing retardation, as the gap between cultural expectation and the child's growth widens. If increasing environmental pressure and/or the child's lack of satisfaction provoke a stronger emotional reaction in the child, stasis may give place to regression, a search by the child for lost emotional satisfactions of an earlier period.

Reference has also been made in Chapter 6 to two main variables in children's behaviour patterns, variables of quality and quantity of behaviour respectively, which influence temperament and durably affect behaviour. The delineation of the temperamental traits arising from these is a major issue in the description of clinical syndromes.

The main clinical syndromes can most conveniently be reviewed by a recapitulation of the time classification employed in the text. Obviously, each phase will lead into the next and may to a large extent affect the pattern of disturbances which emerge in later phases.

PREGNANCY AND BIRTH DIFFICULTIES

The difficulties that stem from gestation and parturition have in common the fact of somatic damage. In the case of infections, irritations, metabolic and endocrine disorders, mongolism, placental disease and malnutrition, these tend to affect parts of the body in addition to the central nervous system, and to some extent this is true also of germ plasm failure resulting in primary mental deficiency.

Thus congenital mental deficiency, though it may be accompanied by many bodily anomalies, will present primarily as a severe all-round retardation of development. The partial deficiencies that are sometimes met with, should more properly be considered as primitive disorders of relationship formation; though such children may operate at a level of mental deficiency, this will be due not so much to their deficiency as to their malfunction. The

development of mentally defective children will follow a more or less normal pattern, provided that the social environment allows this; but the time relations may be greatly prolonged. If, after observing the child over a period of about 2 years, it is not possible to perceive a scale or pattern of development that enables an accurate forecast to be made of the future outcome, the condition is unlikely to be straightforward congenital mental deficiency. The cases of *Maurice B.* (6); *April P.* (7); *Christopher D.* (8); *Penelope M.* (9). illustrate *simple amentia*.

The disorders caused by foetal brain damage will be mainly neurological. The cases of *Paul Y.* (2); *Alan T.* (3); *Brian B.* (4); and *Michael L.* (5), show that the outcome may depend less upon the nature of the deformity than upon the child's reaction to his situation, and upon parental attitudes and handling.

SERIOUS DISORDERS OF RELATIONSHIP FORMATION DURING THE FIRST YEAR

THE EGO-FORMING PERIOD

Elsewhere the author has suggested a classification of the effects of gross failure in relationship formation:¹

- (a) Total failure of primitive orientation—*profound idiocy*.
- (b) Partial failure in and disorder of primitive orientation—*idiocy with catatonic features*.
- (c) Disorder of the first human relationship (with the mother): *anomalous idiocy*, of two main types—*withdrawal* and *autism*; and *extraversion* and *hyperkinesis*. *Affectionless psychopathy* also has its roots at this period.
- (d) Disorders of orientation in space and in motor activity—*anomalous idiocy*, *autism*, and *hyperkinesis* develop their most characteristic phenomena during the orientation phase.

Profound idiocy is the extreme degree of simple amentia; idiocy with catatonic features differs from anomalous idiocy in virtue of fragmentary traces of orientation and development found among the latter. Here, instead of using the term anomalous idiot we shall regard this condition as the *primitive psychosis of childhood*, in view of the marked disorganization in the relationship of the individual with the environment. These cases have, in common, a severe frustration of the developing social instinct. Withdrawal was shown by *Norman R.* (10); *Raymond W.* (12); *Muriel L.* (13); *Maureen M.* (14); and *Angela C.* (15). *Mark N.* (16) also showed withdrawal, earlier, but his high intelligence and later degree of orientation and recovery comprised a fascinating problem of diagnosis. Hyperkinesis is represented by

¹ See *Tredgold's Textbook of Mental Deficiency*, 9th Edition, by R. F. Tredgold and K. Soddy. Baillière, Tindall and Cox. London, 1956, page 166.

Clare K. (11). The preponderance of cases of withdrawal seen in clinic practice may be due to the acuteness of the management problems raised by hyperkinetic psychotic children which will lead to their early institutionalization.

THE SUPER-EGO FORMING PERIOD

Examples are given in Chapter 9 of disorder of orientation in space and motor activity during the super-ego forming period. All such children will have a defective body image, a feature conspicuously shown by *Robin S.* (38). At this stage, autism and hyperkinesis will be less antithetical than in the case of the more primitive examples, and even very withdrawn toddlers may show bursts of uncontrolled activity. *Phyllis B.* (34) and *Suzanne B.* (35) were mainly autistic, with very little sign of recovery. *Tim T.* (36) and *James L.* (37) developed some degree of rather disordered reorientation. *Jacky H.* (39) lived his life entirely on the surface, and was extremely hyperkinetic. These children had a marked deficiency in their capacity to love, though with the exception of *Jacky*, they needed and could accept simple bodily comforting.

LESSER DISTURBANCES OF RELATIONSHIP FORMATION

The cardinal feature of cases illustrated in Chapters 8 and 10 was the comparative lack of satisfaction of the children in their infant suckling experience. In varying degrees, they had all perceived the maternal relationship, not in pleasure, trust and acceptance of instinct modification; but in frustration, lack of satisfaction, self-compensation and rejection of instinct modification. Such children cling to babyhood and are unadaptable; they are slow and late in acquiring new capacities and tend to regress whenever things do not go smoothly.

When the child is seen first at the age of 5 years or more, the specific first-year difficulties may have been submerged in later problems. Diagnosis will depend upon a detailed and reliable history of the first year of life, which will be often not forthcoming. The presence of a first-year difficulty may be inferred from the ubiquity of the disturbance. The child will show a characteristic pattern of disturbance in every aspect of his life—to growing up in general, to approaching new experiences, making friends, feeding, sleeping, acquiring bodily habits, and so on. Even a more specific first-year weaning difficulty will tend to irradiate and affect the child's general attitudes.

Difficulties which first appear after early infancy will tend to be more localized. For example, second-year difficulties might impair the child's control of his feelings, but provided that his feelings were not closely involved, he might make friends, eat and sleep satisfactorily. Such a child may have a compensating strength or felicity, such as generosity or intellectual efficiency,

that may smoothe the path of difficulty for him. A child who is disturbed at a first-year level, typically, cannot be generous because he is too insecure at a primitive level and, for the same reason, cannot apply his intellect efficiently.

First-year disturbances are usually related to early infant feeding experiences, of which a minority will have been unresolved at the time when weaning is attempted. They have been presented under the heading of *Modification of Instinct*, because usually they are first revealed during weaning. The in-turning or the out-turning pattern of temperament when present, will dominate the clinical picture; the former represented by *Ann T.* (17) and *Peter P.* (18); the latter by *Tony N.* (19) and *Simon L.* (20); and a mixed pattern by *Cecil C.* (21) and *Charles S.* (22). A greater degree of activity was evident in the cases of *David B.* (25) and *Robert L.* (26); and pronounced inactivity in *Graham B.* (27). *Daphne R.* (28) was both inactive and showed some depressive features. Anxiety related very obviously to chronic feeding dissatisfaction was demonstrated by *Janet S.* (23) and *Miriam G.* (24).

Restlessness and overactivity were concealed in the case of *Douglas C.* (29) by inhibition derived from strong parental control during his second year. Some of the children had reacted with strong anxiety to weaning that was either too sudden or carried out too rigidly: *Caroline N.* (30) regressed, *Harry D.* (31) was tense and anxious, and the full force of *Hugh A.*'s (32) anxiety was hidden for some time. *Rose Y.* (33) rejected weaning as far as lay in her power, and vigorously clung to babyhood.

PSYCHOSOMATIC REACTIONS

Psychosomatic disorders are an exception to the principle that first-year disturbances are non-specific. Once established, a psychosomatic reaction appears to become the standard stress reaction of that individual. Unlike some adult conversion hysterics, a child will get little relief from anxiety during psychosomatic attacks. The illustrations in Chapter 10 are taken from the eczema-bronchitis-asthma group and various allergy phenomena, and diarrhoea with or without ulcerative colitis. Cyclical vomiting is more typical of 'latency'; and psychogenic headache, unless it forms part of the cyclical vomiting syndrome usually appears during childhood only as a result of suggestion by an adult. Other adult psychosomatic disorders rarely occur during childhood, except for a neurasthenic or 'effort syndrome' attitude occasionally induced by unwise handling of a 'latency' child with a heart murmur, and an occasional case of peptic ulcer.

However, the psychosomatic disorders of childhood will include the disturbances caused by special sense defects, and the deleterious effects of symptoms *per se*, such as bedwetting, soiling, thumb sucking, nail biting and masturbation; or on a different plane, feeding difficulties and sleep disturbances.

Eczema, Asthma and Bronchitis. The first to appear is eczema. The original skin trouble will set off a chain of stresses and reactions which may lead to asthmatic attacks, and the associated 'striving', or tense and inhibited personality. This sequence was well shown by *Daisy P.* (40); *John H.* (41); and *Hilda N.* (43). *Gladys N.*'s (42) skin trouble was traced to a feeding allergy. Asthma is common without eczema, or it may be associated with a chronic allergic state of the upper respiratory tract—*George Roberts* (91). The personality concomitant of asthma may be concealed if the child is markedly out-turning, yet inactive, and especially if he is highly intelligent—*Stephen N.* (76).

Diarrhoea, Ulcerative Colitis. Diarrhoea is the great scourge of the unhappy infant, and its effects will be reflected in parental anxiety and, maybe, loss of confidence. The personality type that goes with chronic infantile and toddler diarrhoea is more overtly anxious, less 'striving', more submissive and more regressive than that of asthma. The well recognized association between lack of fortitude and looseness of the bowels was evident in *Shirley P.* (44) and *William J.* (45), the latter also developed headaches, by suggestion. *Aubrey B.*'s (46) ulcerative colitis seems to have been associated with uncontrollable parental anxiety.

Blindness, Partial Sightedness. Blind and partially sighted young children, before speech is established, who are not in constant feeling contact with their mother, will have correspondingly fewer opportunities for orientation and organization of perception. The high incidence of autism and supposed mental deficiency among blind babies brought up collectively, demonstrates their vulnerability. *Jeremy N.* (47) was an example. *Edward K.* (48) was well nurtured in infancy, but reacted with hostility at an oedipal level to the brusque interruption of his love relationships. His blindness appeared to have exacerbated his reaction. Relationship formation difficulties commonly lead to retardation of emotional development, to clinging, over-dependent and babyish behaviour among blind children.

Myopia. The effect of refractive errors on early child development is little known, because of the difficulty of early recognition of the defect. The in-turning *Kate O.* (49) was timid, clinging and babyish; while the out-turning *Bernard P.* (50) was a danger to himself and others in his reckless, clueless and fearless lack of perceptiveness and of organization of his experiences. *Hypermetropia.* In contrast to the above, the in-turning *Philip K.* (51) was clumsy in movement and incompetent in judgments of space relationships; he was unorganized, unadaptable and with rigid, quasi-obsessional reactions. *Joe L.* (52) was more out-turning, truanted constantly and for him life was all mixed up.

Total and Partial Deafness. *Gordon R.* (53) had the common difficulty of the partially deaf child in refining his relationships beyond the level of simple

body communication and, being mildly in-turning, was in poor communication with the world. *Eric G.* (54) was markedly out-turning but suffered a sudden and traumatic loss of hearing. His struggles to re-establish communication resulted in anachronistic behaviour and he antagonized those who should have helped him. *Dennis K.* (55), totally deaf from birth, somehow managed in spite of emotional neglect to adjust at a baby level of simple bodily satisfaction. His failure to make more abstract relationships appeared to be delinquent, even psychotic, to those who ought to have helped him.

Proprioceptive Defects. Difficulties of orientation and organization due to defects of proprioceptive sensation were shown by *Paul Y.* (2) and *Michael L.* (5).

GENERAL SECOND-YEAR PROBLEMS

The common theme of second-year disturbances, illustrated in Chapter 11, is disorder of the control and employment of aggressivity. Out-turning and aggressive reactions are represented by *Tommy T.* (56) and *Martin B.* (57). They had in common, disturbances during the second year, sibling jealousy, and rigid parental discipline and over-control. They were basically secure enough to be aggressive at home, hateful, jealous and domineering, but with great anxiety too. Outside the home, *Tommy* though gregarious, was timid, fearful and clinging, but able to form positive relationships with younger children. *Martin*, with a stronger masculine identification, rebelled more successfully at home, but with greater anxiety. At school he was more domineering than *Tommy* and provoked hostility there too. Unlike the overall reaction pattern of the first-year disturbed child which is constant in all life situations, these 'second-year' children showed more specific patterns of behaviour in different situations.

In-turning and inhibited reactions are represented by *Derek G.* (58) and *Keith J.* (59). Both children had loving, but dependent, relationships at home. *Derek's* failure to progress from infantile habits had undermined his self-respect. Undoubtedly he was mother fixated, but his troubles long predated the Oedipus phase, and involved predominantly his capacity to utilize his aggressiveness. *Keith's* father's anxiety predisposed *Keith* to an adverse reaction to his brother's birth and his inhibited aggressiveness was shown in stubborn difficulties over toilet training and by nail biting. He also had a positive organizing reaction in his obsessional tendencies and his split feelings: his jealousy of his next brother and compensating love for the baby.

Both *Derek* and *Keith* had some specificity and localization of disturbances, but it is perhaps more characteristic of second-year problems to have these in greater degree. Uncontrollable irascibility was characteristic of *Martin B.* (57) and emotional retardation dominated the clinical picture in the case of *Rodney H.* (60). *Rodney's* over-dependence on his mother predated the

Œdipus phase and was characteristic of a second-year failure to achieve psychological 'weaning' from infancy.

Another common aggression difficulty—inhibition, over-control and over-goodness can be seen in *Barry R.* (63), who was 'too docile, lacking in energy, and wouldn't try'; and who, like *Rodney*, later on failed in differentiation of sexuality.

Commonly aggression difficulties will be resolved by over-organization and obsession formation. *Leslie W.* (61) was disturbed by tension between his parents. His obsessional and compulsive behaviour derived from primitive magical thinking by which he sought to control a disorderly world. Though unable to write at 7½, he had 'an unusual flair for clocks and calendars, for mental arithmetic and for telling in a flash the date of next Thursday week'. *Giles R.'s* (62) obsessional behaviour had something to do with the huge discrepancy between his dull intelligence and that of his university lecturer parents. At 4 *Giles* had a compulsion to repeat almost every word or action from three to six times, as if these were formulas to solve his problems.

DISORDERS OF ORIENTATION IN SOCIAL RELATIONSHIPS

The resolution of Œdipus or Electra situations may occupy the period from the toddler phase until school entry age, and is, perhaps, the most important super-ego forming influence (see Chapter 12).

For the *boy*, the range of patterns of resolution will include:

1. Reaction of rejection:
 - (a) conflict with father: domination, 'castration' anxiety; submission; inhibition of aggressivity and obsession-compulsion formation, tics, nail biting, etc.; inhibition of masculinity
 - (b) father dependence: passive lack of sexual differentiation, over goodness.
2. Over-identification with father: devaluation of femininity; potential active homosexuality.
3. Persistent regression: maintenance of the *status quo ante*.
4. Identification with the mother:
 - (a) infantile overdependence: babyishness
 - (b) lack of masculinization: 'tied to mother's apron strings'; possible bisexuality
 - (c) feminization: possible feminine-type homosexuality.

For the *girl*, the homologous patterns will be:

1. Reaction of rejection: conflict with father: domination; relatively weaker anxiety reaction and 'penis envy' (feminine inferiority); weak inhibition; infantile level identification with the mother.

2. Over-identification with father: the 'tomboy'; potential active homosexuality.
3. Persistent regression.
4. Identification with the mother—passive over-compliance; possible passive homosexuality.

Additional features of this period are: resolution of sibling rivalry, formation of peer group relationships, and emergence of creative thought processes that may tend to increase anxiety.

Among the boys, *Patrick T.* (68) is an example of father rejection, attempted domination and 'castration' anxiety. An inhibited reaction with anxiety, over-dependence on the father and over-goodness was shown by *Gerald D.* (67). A more markedly somatic anxiety reaction characterized *Leonard P.* (72), whose conflict with his father was exacerbated by lack of maternal support. *Roy L.* (65) showed lack of masculinity of identity formation, at the end of a long family, with a dominating mother and a remote father. *Walter R.* (73) grew up in a feminine world with strong babying influences, and lacked a sufficiently strong masculine identification to become a real boy. *Ian P.* (66) was even more feminine in his reaction than *Walter*, with strong identification with a mother who thought of him as a 'tomboy'.

Among girls an aggressive, domineering reaction may cause somewhat less anxiety, but this was scarcely true of *Rita H.* (70) who, though she stoutly resisted her rejecting mother, was nevertheless a prey to violent anxiety, with psychosomatic troubles and obsession formation. In the case of *Marcia M.* (69) both her anxiety and her defences were strong and she dominated her mother, while maintaining loving relations with her father and intense jealousy of her siblings. *Audrey G.*'s (71) anxiety was so intense that she became severely inhibited. *Myrtle M.* (64) was the most dominant of the four girls, but strikingly ambivalent. Her markedly feminine reaction, strong mother identification and contra-sexual attraction with her father contrasted strongly with the masculinity of her rough, hectoring behaviour.

There is no clear example in the series of that rare condition described on page 281 as 'psychological parthenogenesis', in which the mother's narcissism inhibits her daughter's sexual development. Something of the characteristically immature but feminine sexuality can be detected in *Myrtle's* relationship with her mother.

None of the ten children whose cases illustrate Oedipus and Electra problems were ineradicably maladjusted, though cure or alleviation might take a long time. *Betty E.* (74) is an example of a gross breakdown in early oedipal relationship formation, disorganization and psychotic regression, and subsequent partial reorientation and recovery. Children only rarely become disoriented in this way after passing the second-year phase of development, but examples of earlier breakdown can be found in Chapter 9, cases (34)–(39).

PROBLEMS ARISING DURING THE INFANTS' AND JUNIOR SCHOOL AGE

There is less that is specific about disturbances that can be related mainly to 'latency', for the children concerned generally bear traces of earlier difficulty. However, the specific strains of the 'latency' period may revive old problems and give them the form of more advanced intellectual and social expression. An in-turning, withdrawing reaction was shown by *Albert L.* (75), whose daydreaming was marked. *Eileen H.* (82) had a similar, but more depressive reaction, with many psychosomatic features. *Clive V.* (83) was of similar temperament but had a severe psychosomatic breakdown.

A typical over-active, out-turning 'latency' reaction was displayed by *Daniel L.* (80), with enormous restlessness and distractibility. *Frank S.* (79), equally out-turning and active, suffered lack of understanding and social difficulty that made him appear as an aggressive delinquent. *Stephen N.*'s (76) out-turning nature was masked by inhibition, and his symptoms were canalized into psychosomatic illness—mainly cyclical vomiting. A similar reaction, though tenser and more excitable, was evident in the case of *Colin Smith* (88). *George Roberts*'s (91) inhibition was seen both in psychosomatic troubles (asthma and bronchitis) and in the reduction of his fine intellect to academic mediocrity and a fantastic spelling disability. *Roger N.* (81) was a monument to despair and inhibition arising from intense parental disappointment.

Vera P. (77), *Joan E.* (78), and *Frank S.* (79) were delinquent. Delinquency has not been singled out for separate consideration in this volume, because it includes varied symptomatic behaviour to which the attitude of society contributes its one common feature. Delinquency mainly provoked by social attitudes and environmental pressures is of less concern to our present study than that arising from intrapsychic pressures out of faulty instinct modification patterns. *Vera* was deprived of her infantile birthright of love, and in her insatiable search for satisfaction appropriated the best available substitute. *Joan* harboured more hatred and revenge—something of an urge to destroy her parents, and herself. *Frank*'s problem was his relative inability to control his infantile type of impulses towards the immediate gratification of any whims he might have. These children illustrate three of the four main streams of delinquency. The fourth came to be illustrated later by *Jacky H.* (39) when, after 'latency', he became better oriented to a simplified social environment through cognitive perception rather than emotional relationships. He was an affectionless, irresponsible psychopath whom only strict external control could save from criminal behaviour and restrict his delinquency to total selfishness of behaviour and lack of consideration for others. Had *Joan* been more nearly affectionless, with her resentment and motive for revenge, her behaviour would have been very hostile, aggressive and dangerous.

Usually, comparatively few new problems will present during the junior school period. If the child has adjusted to earlier stresses, with two common exceptions, no new sources of strain are likely to cause a breakdown, barring accident, illness, bereavement, or family disorders. The exceptions are the grammar school entrance examination; and mounting pressure of school failure, when the latter occurs. In some ambitious middle-class London suburban families, parental anxiety and heavy school pressure can form a dangerous combination. This situation is well illustrated in the cases of *Derek G.* (58), *Stephen N.* (76), *Roger N.* (81), *Jean and Colin Smith* (88), *Brian and Miriam Brown* (89), and *George and Henry Roberts* (91). However, breakdown is uncommon except through the reactivation of old anxiety.

PROBLEMS OF ADOLESCENCE

We have compared 'latency' with a kind of 'Age of Reason' and have also described the psychological ferment that, about one year before puberty, ushers in the more 'Romantic Age' of adolescence.

The conflicts of adolescence, like those of the oedipal period are wider than the narrow range of genital sexuality, and their recurrent theme, likewise, is authority, the attitude to the father being commonly broadened to include the abstract father, or authority, figure.

The danger that father or mother fixation may be protracted into homosexuality is increased by the social and super-ego obstacles to early heterosexual fulfilment. In addition, the ubiquitous reaction of regression may be more damaging during adolescence because of the greater personal responsibility of the individual during that period.

The defence mechanisms of adolescents will include creative activity that may degenerate into a flight from reality; combination and organization into group or gang formation that may have an anti-adult purpose; and the evolution of rigid codes of behaviour which, though they may be unacceptable to adults, deserve treating with circumspection.

The peculiar theme of adolescent disorders is the intensity of the anxiety or other emotional imbalance that can be generated, and the dangerous tendency of some deeply disturbed adolescents to withdraw from reality towards psychoses. Acute generalized anxiety at puberty, characteristic of some adolescent girls was shown by *Sally N.* (85) who, undermined by chronic poor family relationships, suddenly collapsed in face of enlarging responsibility, but who recovered quite rapidly. *Arthur L.*'s (84) anxiety was deeper and more directly sexual—typical of the boy rather than of the girl—and he was very seriously regressed. His mother showed something of the 'parthenogenesis complex' and Arthur's sexual retardation was the male counterpart of the permanently infantile, 'little girl', attitude described in Chapter 12.

Ruth V. (86) showed a seriously withdrawing deteriorating reaction to

acute generalized anxiety, coupled with an obsessive-compulsive over-organization. Her later psychic disorganization indicated the probability of incipient schizophrenia. In the case of *Herbert F.* (87) the process of disorganization was more marked. He had had an inhibited and obsessional resolution of the Oedipus situation, and at adolescence his anxiety was acute and specifically sexual.

DISORDERS OF FAMILY RELATIONSHIPS

The families described in Chapter 16 illustrate the different reactions which may be found among various members of a family exposed to a common stress. Reactions will vary according to the age of the exposed child and the quality of his relationships. The actual nature of the stress is often surprisingly unimportant.

The *Smith* family (88) were upward mobile socially, the parents were ambitious and driving, and over-careful. The girl had a severe oedipal anxiety and the boy had acute second-year psychosomatic reactions. In the *Brown* family (89) the severely handicapped older boy, whose father behaved especially hatefully towards him, was saved by the strength of his early relationship formation with his mother, and the brunt of family anxiety was borne by the younger girl and boy. The *Jones* parents (90), though well intentioned, were overwhelmed by twins arriving soon after their older child, and failed to give them adequate security. The *Roberts* family (91) was peculiarly tragic, in that the inadequate father, because of the strength of his emotional conflict, behaved cruelly, at variance with his ideal character. The older boy showed mainly latency, and the younger oedipal, difficulties. In the *Scott* family (92), parental sexual psychopathy caused a dangerous feminine type of oedipal reaction in the younger boy; but the older boy who was adolescent at the material time suffered a psychosomatic anxiety breakdown. The problem of the *Evans* family (93) was that of social inadequacy, and the father was the more inadequate parent. The older boy had severe oedipal difficulties and the younger a second-year level of fixation. The girls got off comparatively lightly. The 'social problem' *Green* family (94) was quite paradoxical. The family atmosphere was most disorderly and, one would have thought, pathogenic; but somehow, the children formed sound basic relationships. The oldest boy had difficulties at a super-ego level, and one of the girls was emotionally maladjusted due mainly to separation from the family at critical periods!

These families illustrate the principle that each child's case must be examined individually in the light of what actually happened to that child and at what period of his life. It is merely misleading to cite family or social circumstances in a general way.

Chapter 18

Examination, Diagnosis and Disposal

CHILD guidance clinics receive cases from school medical, social and psychological services; maternity and child welfare services; general practitioners; local authority children's departments; other social agencies; juvenile courts; and from parents themselves and friends of the family. It is important that clinics should be accessible to anyone in need, even, as in an actual case, to an exasperated father who looked through the telephone directory until he saw something promising.

The principle of availability does not reduce the importance of the manner of introduction of the parents to the idea of 'child guidance'. The referring agency needs to attune its approach to the individual case; the most unpromising cases are often those in which the parents profess not to know why they have come. One mother thought she was going to hear the result of her child's X-ray taken at another hospital. A worse experience was to receive four 14-year-old girls unexpectedly, with a note from their headmistress requesting sex education, and explaining that improper notes had been intercepted in class!

It is difficult to recover from a bad start caused by thoughtlessness, ignorance or moral cowardice of the referring agency. Missed appointments, cancellations, and failures early in treatment are related inversely to the care and skill with which the preliminary contacts have been conducted.

The clinic's responsibilities start from the moment that referral is mentioned to the parent. Child guidance problems usually evolve from a complicated ætiology, often over a period of years. It is rarely possible to apply a specific cure, but instead, the patient and family will need help to grow together towards alleviation and improvement.

A small proportion of cases can be helped by simple, direct measures, but a high proportion will need psychotherapy, which is costly in professional time. Most clinics are encumbered by long waiting-lists for treatment.

THE DIAGNOSTIC PROCEDURE

Except in the rare case of urgency it is a sound plan to give the parents about 3 weeks' notice of their first attendance. This enables the family to adjust to the idea of attending, and the clinic to obtain school, hospital and other

reports. Many PSW's like to visit the home in the intervening period and, if successful, will gain a more vivid impression of the atmosphere. However, many parents cannot tolerate an intrusion into the home, and circumspection is desirable.

CHILDREN OF SCHOOL AGE

Psychological Testing can usually be arranged conveniently at the first visit, while the PSW takes the social history from the parents. It resembles the classroom situation sufficiently not to be disturbing, except when the child is failing at school.

At the first visit it is only practicable to administer a standard intelligence test, and perhaps, short attainment tests in basic school subjects, e.g. reading and number. The psychologist will also assess the desirability of giving other intelligence and aptitude tests, and of personality assessment by projection methods, at a later interview.

The Psychiatric Social Worker's Interview. The purpose of the first PSW interview reaches beyond the social history into the establishment of a therapeutic relationship with the parent. Valuable information can be gained by leaving the parents free to decide which of them (or both) should accompany the child.

The PSW will get the best results from a passively receptive attitude, allowing the parent to tell her story in her own way. This will often be incompatible with comprehensiveness of history taking, but gaps can usually be filled in later. The whole procedure of the diagnostic examination should be discussed with the parent, and the PSW will usually glean some information about the parent's attitude to the possible recommendation, say, of regular treatment, or of boarding school and so on. The patient should be warned that a decision may take some time to make, and in appropriate cases a later interview to discuss the findings in full should be offered.

The Psychiatric Examination. The object of the psychiatrist's first interview, is to establish a therapeutic *rapprochement* as well as to make a diagnosis. Every scrap of information about the child can be important. Briefed with the essential findings of the PSW and the psychologist, the psychiatrist is well advised to go to the waiting-room and make a friendly contact with the party there. It can be informative to note exactly what the members of the family were doing and how each individual reacted upon his entry. Once, an 11-year-old boy of very superior intelligence had been brought by his over-anxious mother 40 minutes early. He was lying back in a chair, holding a comic in his hand, but talking loudly to his mother, when the psychiatrist entered the room. The boy said loudly 'And about time, too!' and disappeared behind his comic. The mother's mortification had to be dealt with, but a major lead had been gained into understanding the family's difficulties.

It is important to note the child's appearance and social deportment, gait and his way of negotiating physical obstacles. A flight of stairs is especially useful. The consulting-room interview should be structured so that a standard set of toys and play material is on view, appropriate to the age of the child; but it should also be free in the sense that no programme is mapped out for the child, merely a general invitation to look at the toys. Children of about 11 and upwards may feel insulted by toys strewn around the room; and for them it is better for toys to be on a shelf in full view, and a deprecatory remark made to the effect that the younger ones like to play with them.

It is wise not to attempt to penetrate the child's defences during a diagnostic session; far better merely to note his behaviour and what is said. Common defences of children are: to stand inhibited just fiddling with the toys, perhaps very close to the doctor; withdrawn absorption or tremendous activity with the toys; and a flood of talk. Questions should be neutral, designed merely to encourage. An angry or hostile child should be prevented, if possible, from saying or doing damaging things at the first visit, lest guilt be added to the existing burdens of the child. Physical examination should be avoided, at least until the child is known better. An imaginative child will sometimes respond to playing a game of three wishes granted by a fairy godmother. An artistic child will sometimes express himself best in painting or drawing.

It is often particularly rewarding to compare the child's behaviour in the free psychiatric interview with that in the psychologists' structured interview, where it was demanded of the child to perform certain tasks.

The refusal of a school child to be separated from the mother in the clinic would be an important reflection of the child's (and the parent's) attitude.

PRE-SCHOOL CHILDREN

The case of pre-school children will be altogether different, and a flexible procedure is desirable. Easy separating from the mother might indicate basic confidence and harmoniousness; or indifference, apathy or poverty of relationship formation. It is profitable to attempt gently to get the child on his own and watch what happens. Success in the attempt will provide a comparison between the child's behaviour alone and with his parent; but the manner of a failure would be equally of interest.

By-play between parent and child can be absorbingly interesting. Some parents' attitude to the examination deserves the term 'sabotage', though it be unconscious. Take for example the parent who finds it hard to understand what is required, and then says flatly; 'Oh! I don't expect he'll want to go by himself'; or volubly exhorts him to go alone, in a rising tide of anxious pressure. More subtle sabotage is the long-lingering look, while fussily taking off the child's overcoat and repeating 'it's only for a minute, darling', or other petty manoeuvres. It is probably true to generalize that a

child's failure to separate from his mother will be due to her conscious or unconscious wish for him not to.

Children under 2 are best observed with the mother present; apart from encouraging her to cope with the child, beyond providing suitable premises and toys the observer is well advised to be inactive. However, observations should be methodical, paying attention respectively to the quality and quantity of the child's behaviour, responsiveness to his mother and she to him; his motor capacity; language; level of ideas; interests; and social capacity. Methodical observation will enable a more reliable overall assessment to be made, but the clinical assessment of children's development is difficult and requires constant practice, because it is remarkably easy to get out of touch. The lability of children's regressions when in temporary difficulty reduces the reliability of development scales.

PRINCIPLES OF DIAGNOSIS

Exact diagnosis will depend upon an accepted pathology, which is lacking in child psychiatry and without which no more than careful description of phenomena and weighing of ætiological factors can be attempted. It does not help to assign names to the phenomena described, as if they were diagnostic entities. Terms borrowed from adult psychiatry, like anxiety neurosis, hysteria, obsessions, and compulsions reveal nothing useful about when and how the child's condition arose, nor do they enable a prognosis to be made.

In this book, the diagnostic effort has been directed towards defining the child's reaction type, fixing the period at which the difficulty started and delineating the pattern of interaction between the child and his environment (see page 97). The chief disadvantage of this method is its dependence upon the history given by the party or parties most interested personally. The possibilities of distortions, omissions and inventions, both conscious and unconscious, are enormous.

To overcome this disadvantage, the psychiatrist must have an intimate and sympathetic knowledge of the community or social milieu of the patient and must understandingly scrutinize all information for inconsistencies, unlikely features and improbabilities. Reliability of diagnosis will depend upon the elucidation of a consistent and recognizable pattern of family behaviour.

DISPOSAL

Next we shall consider what can be done for cases, short of psychological treatment of the child (see Chapter 19). The methods at the disposal of the child psychiatrist will include: counselling and supervision; social adjustments—housing and 'straight' social work; educational adjustments—change of school or class, influencing teachers' attitudes, arranging special types of education; placement in a residential school for maladjusted

children, or a special hostel or home; hospital placement; and advisory services for children under public supervision or residential care.

SOME PRINCIPLES UNDERLYING DISPOSAL

The therapeutic aim will depend upon assessment of the trends towards health in the family and the child. At one end of the scale of problems is the broken home or the child already in public care. Here the task of the clinic will be to work for the best possible circumstances of life for the child. In the case of families in or near the 'social problem' group it should be recognized that there is a critical level of social competence below which families are unable to make use of child guidance clinics.

Child Guidance is useful only to those who have some capacity to help themselves. Some 'problem' families will regard the social and public services as their natural enemies or as opportunities for short-sighted exploitation. If the family be totally bewildered and rudderless, child guidance will merely add another to the long list of failed efforts, and so confirm the family in its hopelessness, as the Thomson family will illustrate. They lived in 2 rooms in a down-town tenement; Jean, the third of five children was 13 years of age, was dirty and dishevelled and the despair of her secondary modern school. After the failure of many attempts, a 'Problem Cases Conference' decided at length to try Child Guidance. After the family failed the first appointment, the school social worker visited and was met with voluble excuses. The youngest child could not be left, for he had a bad cold. The social worker arranged to call with a car next morning and take the whole family, if need be. Mrs. Thomson was profuse in her thanks, but next morning she and the three younger children were still in bed when called for. There was still ample time to get there, but Mr. Thomson was on shift work and expected home at any moment, and had to have a hot meal. The social worker called some days later and was told that Mr. Thomson did not agree with Jean going to the clinic. Mrs. Thomson was sorry but daren't go against her husband. Such families can be helped, if at all, only by domiciliary methods.

At the other extreme is the 'good family', but work with the 'good family' is not always plain sailing. When worthy well-meaning people get into trouble because of emotional insecurity, personality difficulties, illness or accident, they may vacillate between anxious self-questioning and projecting their difficulties on to the child. 'I can't understand it', they may say, 'she's got everything she can possibly want and it doesn't satisfy her'.

Gross defects of relationship formation (see Chapter 7) will not usually respond to child guidance methods, though it may be possible to help the family to live with the disability.¹

In the case of less catastrophic relationship disorders, if the child's condition

¹ See footnote to page 419.

has been provoked largely by parental deficiencies or psychopathy, it may be advisable to consider residential placement. Otherwise the therapeutic agencies may find that they will have to attempt to use in treatment the same influences that have mainly caused the disorder.

Peculiarly difficult to help is the parent who can find no good word to say about the child. However angry or vituperative, if there is any health in the relationship, a parent will always show some relenting of attitude after the nasty things have been said; some remark like: 'Well I must say he's kind to his little brother.' *Martin B.*'s (57) mother, though sadly at odds with her son, was bound to him by his need to be loved last thing at night.

Impermeable disaffection of the parents need not preclude therapeutic effort for older children, especially for adolescents who have developed some compensatory mechanism. *Hilda N.* (43) responded unexpectedly well to treatment, but a year later her mother wrote a letter that was unchanged in its attitude of total rejection (see also page 449).

Careful examination of the pattern of unfolding of the difficulties will enable those cases with some tendencies towards spontaneous recovery to be distinguished from those in which difficulties are cumulative, a distinction which has little relation either to acuteness or severity of disturbance, or to optimism or pessimism of the parents.

When there is some spontaneous tendency towards recovery, counselling and supervision will often break a vicious circle, relieve anxious pressure and enable recovery to proceed. Cases in which the difficulties are cumulative do not respond to counselling and supervision methods alone, but if the child and parents have some capacity to form loving relationships, long-term psychotherapy should be considered (see Chapter 19).

COUNSELLING AND SUPERVISION

Child guidance counselling must seek to do more than merely give advice. These families have more than enough of advice, from relatives, neighbours, casual acquaintances, social agencies or the insurance man. Generally they will accept only what they like to hear and this will leave them making the mistakes that they have been making for years. For the clinic to give advice may merely add another to the long list of advisers who have not helped in the past.

The child guidance clinic worker will do better to set himself out, as far as he can, to live through the difficulty with the harassed parents. To do this requires qualities of empathy and sympathy, combined with ability to handle wisely the inevitable transference and counter-transference. Abreaction is not enough by itself, for it will almost certainly add to the parents' guilt and anxiety at first. The counsellor must help the parent to live with his or her emotions, not only in the clinic but also in the stresses of family life.

Counselling should always be a strictly time-limited undertaking, otherwise it tends to slip into an unplanned long-term therapeutic relationship, which is a weak position from which to start more intensive treatment, should this be necessary. An appropriate aim is to help the parent to see the family situation a little more constructively, to see how life might be lived with more success.

Counselling should continue for about three or four visits of the parent, to talk over the situation thoroughly, and to get to see it in better perspective. The counsellor's experience with other people can be helpfully shared with the parents, but the greatest care must be taken to preserve the parents' self-confidence. The most masterly laying bare of the causes of the difficulty, the most convincing prescription for future success, may also have the most devastating effect on the mother's confidence in her own powers and those of her husband. Therefore, the counsellor must go cautiously and impart confidence to the parent by tailing off regular interviews into occasional visits by appointment, monthly, 3 monthly then 6 monthly; and encourage occasional letters or telephone calls.

ENVIRONMENTAL TREATMENT

SOCIAL ADJUSTMENT

Social adjustment is a vast subject and only a few observations in relation to child guidance practice will be offered here. Social difficulties encountered in child guidance practice are more often an *effect* than a *cause* of family maladjustment; but social hardship *per se* may have a serious effect on a failing family. Let us consider the plight of the mother of a 'social problem' family with four children under 5 years of age living in a single attic room that she believes to be damp; up 'three pair of stairs', with a cold water tap on the floor below and all slops to be emptied in the w.c. in the back yard; with a child or her husband ill in bed almost always; and numerous visits to pay to hospitals and clinics; to say nothing of the effect of financial hardship upon a woman who 'cannot manage'.¹

Such gross social problems will tax all the resources of social work in the community. There are many problems of social adjustment, however, among families that are capable of making use of the more refined techniques of child guidance.

Among the social problems affecting 'child guidance families' in London in 1960, that of housing remains the most widespread. The question is the more vexing, because the families with greater social resourcefulness have solved the problem for themselves; but others are suffering great hardship.

¹ For further description of the plight of the problem family, see *Tredgold's Textbook of Mental Deficiency*, 9th Edition, by R. F. Tredgold and K. Soddy. Baillière, Tindall and Cox. London, pages 393-7. Also, A Counselling Service, pages 372-4.

One kind of family particularly concerns child guidance practice. This is that of the couple who married at the end of the war, or while the husband was on National Service, and occupied a room in the childhood home of one of them. At the time of marriage this seemed an inevitable or a sensible arrangement. Other members of the family might have done likewise and the house would be overcrowded. What was a snug little room for the newly wed young couple will become a terrible strait-jacket for three children, especially when an uncle in the house works a night shift and sleeps during the day.

Many municipal housing authorities follow a strangely unjust policy in this respect and decree that a couple with a room in the family house is 'satisfactorily housed', and not to be admitted to the housing waiting-list. These couples have no hope of municipal rehousing, whatever their need. The result is tragically ludicrous, for the policy penalizes precisely those whose immaturity and lack of independence makes them most in need of assistance. This is a strange form of social welfare. However, it should now be acknowledged that, at last, in London the terrible housing conditions are showing some signs of general improvement.

The case of Mr. Jackson is illuminating. He was a skilled engine fitter, with a wife and three children, who was paying 15s. per week for an attic room of his widowed mother-in-law's house, where there was also a colony of his wife's siblings, equally cramped and complaining. Three years previously a social worker had suggested a scheme for house purchase by life insurance by which he would pay a deposit of 13s. 6d. per week for 3 years, and then would get his house at a weekly payment of 17s. 6d. for 25 years (exclusive of rates, perhaps 10s. per week). The recollection still made him indignant: 'No, thank you. Why, I reckoned when it was all over I would have paid about £3,500 for a £2,500 house, and I'm not mug enough to do that sort of thing.'

Mr. Jackson was in such an emotional turmoil that he could not even grasp the terms of the offer; and he had also overlooked that the minimum rent for municipal re-housing would be 45s. per week (inclusive of rates) and might be 60s. Even his wrong calculation would have meant that he was getting a housing loan at $1\frac{2}{3}$ per cent. per annum interest, plus life insurance security. The Jackson's real difficulty was that they could not face the responsibility of an independent establishment.

The role of child guidance in social adjustment is to discover the emotional and often unconscious factors and so contribute to the solution of the problem and, in addition, to interpret the special needs of these families to other social agencies, and the social facilities to the clients. The grand aim will be to build up the strengths of the client families, rather than to buffer them from the worst effects of their weaknesses.¹

¹ See footnote to page 419.

EDUCATIONAL ADJUSTMENT

Just as bad social conditions may make life impossible for unstable families, so bad educational practices can blight the lives of emotionally insecure children. Child guidance is concerned primarily with the school difficulties that will arise from maladjustment; and only incidentally with the converse. Here we shall assume that the educational system provides adequately for the wide range of normal needs of children. Child guidance has to consider what it is that prevents the individual child from making a satisfactory adjustment to learning. We have seen that children's educational difficulties lie mainly in three spheres: intellectual inferiority; emotional immaturity preventing the child from moving into wider relationships; and social disparity resulting in the child's inability to fulfil the expectations of the community, including the peer group.

Resolution of the problems caused by intellectual inferiority may be difficult, because this is not an aspect of education that is popular among teachers; and most parents will resist having their child included among the educational failures. The important consideration is to provide an educational experience according to each child's needs. Most education authorities provide special classes or schools for Educationally Subnormal Children (E.S.N.), which cater for children of the range of intelligence quotient of, roughly, 50 to 70. Children who are more seriously retarded are provided for in Occupation Centres which, to the regret of many people, are the responsibility of the local health authority and not the education authority. This causes interpretation difficulties with parents. Generally this aspect of education is underdeveloped.

The crucial factor in prevention and cure of difficulties of emotional adjustment to school, which are the concern of child guidance clinics, will be the attitude of school staffs. Every child expects to go to school at the age of 5, so that unhappiness there will indicate the presence of strong adverse factors. If, as sometimes happens, the teachers merely feel contempt for the unhappy child and his family, and react with hostility, the child's attitude to education is likely to be unfortunate, to say the least. Strong action will reinforce the child's regression and, if the parents are identified with the child, an *impasse* may result between family and school.

The examples of school entrance difficulties shown in the text include refusal to go; acute psychosomatic troubles; frank misery and failure to learn; hyperkinetic unmanageability; introverted withdrawal into fantasy; inhibition; specific learning disabilities; and, later, truancy. This formidable array of human miseries must be prevented, if possible, and much can be done by teachers who understand children's difficulties, provided that the system is flexible enough to adjust to individual need.

REMOVAL FROM HOME

Removal of the child from home resembles radical surgery in that it is sometimes essential, sometimes the only reasonable possibility, but never to be lightly undertaken. If removal is forced by the breakup of the home, the plan should envisage a long-term placement, if possible.

Removal from home in cases of emotional difficulty between family and child must be planned constructively to foresee the eventual return home of the child; otherwise placement will be no more than a running away from an immediate difficulty.

Much has been written about the dangers of separating young children from their mothers. In the case of older children, it needs to be remembered that nature's model for family life is that of a father and mother together, with unlimited devotion for, say, up to six children, suitably spaced out. Community resources can never be adequate to provide 'normal' home conditions for all deprived children, and further initiative in substitute care methods is urgently needed.

In England, Section 34 of the Education Act 1944 enables suitable children to be placed in residential special schools for maladjusted children, some of which have facilities for individual psychotherapy. These schools can give a comparatively neutral emotional atmosphere to aid the resolution of emotional conflict, but much more needs to be attempted in the way of a community in which each member has a therapeutic role.

Hospital treatment of the emotionally disturbed child is practically unavailable in the United Kingdom owing to too few resources and long waiting lists; and the subject needs a fresh approach, embodying what is now known about the dynamics of emotional relationship formation.

Recent advances in the care of children in hospitals, including daily visiting by parents, have benefited both the mental health of the children and the acceptability of children's hospitals in the community.

OTHER 'EXTRA-MURAL' FUNCTIONS OF CHILD GUIDANCE CLINICS

Co-operation between child guidance clinics and local authority Health, Education, and Children's departments, respectively, can include diagnostic, advice and treatment services for children in care. More integration of child guidance with local authority social services is needed through day by day interchange at a clinical and social work level. There has been a recent important advance in co-operation between child guidance clinics and public health staffs, in the participation of child guidance personnel in the work of Maternity and Child Welfare Services, and in regular discussion groups of child guidance staff and public health doctors and nurses. In a few fortunate localities there is now growing up a more satisfactory sense of common purpose between the personnel concerned, and there is no development of greater promise, in the field, today.

Chapter 19

Therapy

SOME PRINCIPLES OF CHILD PSYCHOTHERAPY

Psychotherapy is the appropriate specialist treatment function of the clinic staff, and in what follows the term 'therapist' is used to include both the medical and the non-medical child psychotherapist.

Psychotherapy with children has evolved by the adaptation to children of methods developed in the psychological treatment of adults and, like the latter, will include the triple objectives of penetrating the patient's neurotic defences, helping him to attain a greater measure of acceptance of self; and building up his strength so that he may find for himself a solution to his problems.

The neurotic defences of children are usually amorphous and their penetration is often a matter of finding out how to enter into reciprocal communication with them. All but the most seriously regressed children will show a greater degree of spontaneous search for a way out of their difficulties, in contrast with the stereotypy of most adult neurotics.

Expressed in another way, the aims of psychotherapy will be, first, to give the child an opportunity of expressing frustrated and largely unconscious instinctual drives and, second, to control and harness these drives to creative living. Thus treatment will begin with a search for an appropriate medium of expression through which the therapist may help the child to 'work through' his own difficulties.

In the case of children, unlike adults, the usefulness of verbal methods is very restricted. Few pre-adolescent children are capable of verbalizing their feelings constructively. Most younger children can express their stronger feelings only very inadequately in words, although their play may be vivid.

Therefore 'play therapy' has been the most favoured mode of psychological treatment; but we must first mention two common misconceptions about 'play therapy'. One is that play creates an atmosphere in which the natural healing powers of the individual can operate, in the sense in which the term, therapy, is applied to 'occupational therapy' or 'music therapy'. The second misconception is that the play itself is curative, as if it were analogous to a specific drug. If these were not misconceptions, psychotherapy could be undertaken in children's play centres.

Play has the significance in psychotherapy of being a good means of inter-

communication between child and therapist. The misconception that play is curative by itself is classically illustrated in the report of an inexperienced therapist about a treatment session: 'John let out a lot of aggression.' All children have to find socially approved ways of 'letting out' aggression and neurotic children usually have difficulty in using their aggression constructively. Many adult patients will find verbal expression for aggression through abreaction, which may be painful, but the therapist will not allow the patient to leave the consulting-room without coming to some acceptance of his outburst, even if the therapist has to bear the guilt himself, temporarily.

Consider the predicament of a child who has lost control, stamped, screamed and shouted, hit, kicked or bitten his therapist, maybe broken a window; perhaps done most of the actions of which he is most terrified. As a result the child will be worse rather than better at controlling his feelings, because of his guilt over the damage that he has done, and his fantasy of the therapist's revenge. 'Letting out' aggression is analogous to draining an abscess, which will tend to spread the trouble rather than cure it unless the source of infection is tackled. Children's aggression in treatment, like that of the adult, must be contained within the therapeutic relationship and not merely 'let out'.

The course of psychotherapy might be divided into three phases:

1. the penetration of the child's defences against anxiety;
2. the experiencing by the child of his real feelings about the treatment situation, at least partly in consciousness; and
3. the experiencing of his true feelings about the reality situation at home and at school; the gaining of control over, and the utilization of these feelings.

For practical reasons, child guidance treatment is usually limited to one visit per week and nothing resembling an analysis can be attempted. The aim will be modest, for normal children have relatively little insightful control of conscious behaviour. Conscious rational control and direction of feelings is, perhaps, inferior to intuition and empathy as a way of learning to conduct interpersonal relationships, and the best objective will be to align the feeling tone of the child with environmental circumstances.

SELECTION OF CASES FOR PSYCHOTHERAPY

The many criteria of selection of cases for psychotherapy are far from clearly defined. One of the most important is the presence of a quality of reactivity in the child's behaviour, some evidence of capacity to enter into loving relationships with another human being, even at an infantile level of emotionality, or in default of a human love object, some relationship with an animal or toy. Disorderliness, aggressiveness or delinquency of behaviour will not be a bar to treatment; but ritualistic behaviour or autistic attachment to fetishes or transitional objects is a sign of potentially great resistance to treatment.

Children with no love and with no human relationship formation cannot be helped by child guidance psychotherapy. Their problem is the establishment of identification of self and environment, and then the development and modification of their instinctual satisfaction pattern, tasks so exacting as to be rarely possible once an autistic pattern has become established.

Another criterion of suitability for treatment is the capacity of the family to co-operate. This extends from availability and accessibility, to the subtleties of parental reaction. Some parents are easily discouraged, others perform heroics in overcoming difficulties and make the child travel many miles and miss much schooling. Heroism may be evidence alike of co-operativeness and goodwill; of a desire for vindication; or a punitive desire to make the child suffer for his misdeeds.

Generally speaking it is a bad sign if the treatment plan does not fit easily into the ordinary life of the family, if supine parents allow minor practical difficulties to outweigh the child's need. Too commonly the parents' attitude will prevent treatment from succeeding.

The willingness of the parent, usually the mother, to join personally in treatment is an important criterion in the case of children before adolescence. Usually the parent will go to the psychiatric social worker, but occasionally she will attend the psychiatrist—*Simon L.* (20); or both will have treatment—*Martin B.* (57).

Lastly, experienced therapists will know their own strengths and weaknesses and will not take on cases out of compassion rather than therapeutic appraisal. They can also recognize when their own anxieties become involved, and it is in this area that a personal analysis most helps the therapist.

THE PHASES OF PSYCHOTHERAPY

I. *Penetration of the Child's Defences.* At the time when the child enters treatment, his conduct, however awkward or crippling, represents the best he can do. Not only should this behaviour be accepted non-critically during the early stages, but the reasons why will need interpretation to the mother.

Serious difficulty may be encountered when the parents tend to encourage the child's neurotic behaviour, e.g. *Gerald D.*¹ (67). Early in treatment, Gerald's frustrated aggression began to find expression, and his mother was horrified to overhear him shouting a (mildly rude) rhyme about the therapist's name. Mild as this was, it represented the most vicious degree of hostility that Gerald had shown up to that time; and the mother's violent reaction delayed progress in treatment for many weeks. The PSW interpreted the mother's reaction to her and, 6 months later, Mrs. D. came successfully through an even more harrowing experience. She chanced to look out of a window at a moment when Gerald gently pushed the therapist who was sitting on the grass, and catching him unawares, knocked him over and sat

¹ See pages 294 and 443.

on his chest. She had developed sufficiently strong positive feelings for the clinic, not to be devastated.

It is not the ultimate aim of psychotherapy to encourage small boys to knock over their therapists and, indeed, cases will be lost prematurely if the mothers are too early faced with the effects of the penetration of the child's defences. Some mothers will abruptly break off treatment in a panic, on the grounds that treatment is making the child worse, a feeling that derives strength from the popular misconception that the psychodynamic approach is synonymous with complete licence for self-expression. Sometimes, however, it is necessary to provoke an aggressive reaction in the child before the task of harnessing and controlling aggression can be attempted.

Success in treatment depends upon the penetration of the patient's neurotic defences. The first essential is absence of hurry, for the main reason that poor adaptability is at the bottom of most children's need for treatment.

The medium of expression for the child should be chosen in relation to the child's age, intelligence, social background and personal experience. Some pre-school children will need first to learn *how* to play, others will need much help to develop even the simplest fantasy expression.

Children of infant and junior school age will usually play without difficulty, but the more inhibited children may use the sand tray or painting as a defence against the therapist's encroachment; and anxious out-going children will often use competitive games similarly, with a feverish intensity, employing fair or foul means in their infantile demand to win. There is a danger here that the child's anxiety arising from his regressive behaviour may augment his neurotic defences.

On the other hand, some children use competitive games to explore their own insecurity and, under the protected conditions of therapy learn to accept uncertainty, defeat, and loss of infantile privileges.

Reuben at 9 was the youngest son of a poorly acculturated and very insecure Jewish refugee couple. In spite of 20 lb. overweight and a figure like a barrage balloon, his mother was convinced that he was a severe feeding problem. She was equally absurd about his 'awful behaviour'. Reuben was a hyperkinetic out-turning boy whose insecurity had provoked a greedy, demanding, domineering, 'thoroughly spoilt' way of life at home. In the infants' school he had come in for a good deal of teasing, but while his generous and affectionate nature enabled him to get on with the peer group at school, he could not learn from the teacher, because he could only accept from an adult something that was anxiously pressed upon him.

In the first phase of therapy, Reuben seized upon board games both as a defence and as a vehicle for the exhibition of demanding behaviour. He recorded every result, and used every fraudulent means to build up a tremendous lead in the number of victories he had gained in a series of 180 games during a few months. He gloated over each little success. For some

weeks the therapist accepted identification with the mother and allowed Reuben to 'get away with it'. His behaviour worsened at home. Then the therapist steadily disengaged himself from the maternal identification, which allowed Reuben to move towards a peer group type of identification. During this manoeuvre the therapist overhauled Reuben's victories, and the boy became more genuinely competitive; cheating became a joke and a way of teasing, and if successful he would be anxious to make reparation. His behaviour became scrupulous to some extent; he became gentler in victory and reasonably generous in defeat.

At school Reuben moved to the top of the class, which reassured his mother. He also gave up overeating and lost most of his excess weight, but this only augmented his mother's fears about his feeding. Thus, treatment had to be continued for the mother's sake long after Reuben had ceased to need it. He was becoming independent faster than she could tolerate. Reuben passed through the three phases of treatment while apparently engaging in the same type of play, but the atmosphere had changed.

Interpretation plays a bigger part in the treatment of school, than of pre-school, children. In both cases, action may be more effective than words, especially in the case of the more out-turning children like Reuben. The best interpretation may be to join in the play and turn the game in the desired direction; or engineer a situation to reach certain important emotional values by means of role playing.

Immediately pre-pubertal children are normally too mature to take to play in the artificial conditions of the clinic. The 12-year-old boy who settles happily to play with lead figures in a sand tray, and the girl with dolls' furniture or whatever is to hand, are probably displaying symptoms. Regressive fantasy may strengthen the child's neurotic defences rather than lay them open to penetration. The child may regard treatment with guilty pleasure, as an opportunity to indulge his regression without losing the esteem of the adult. A mixture of talking about his interests, painting and modelling, constructive activities, pencil and paper games of a scholastic type, making up stories and plays will usually enable the child to express himself. Hyperkinetic and out-going children who tend to act out their feelings need to be given physical activity, which is not only difficult to provide but also does not lend itself easily to the subtler forms of interpretation.

Adolescent children usually take more easily to a verbal approach, but games, pastimes, or activities with an appropriate intellectual content will usually help the shy and inhibited to verbalize their troubles. The first phase of treatment may be extremely long and trying as in the case of *Hilda N.* (43) (see also below). Sometimes intellectual discussion, but not argument, may help towards abreaction; but if this happens verbal interpretation will be needed, including interpretation of the transference situation, and so the case will move into the second phase of treatment.

2. *Experiencing of Emotions in the Therapeutic Situation.* Play therapy without interpretation is scarcely therapy, but only play. Play, especially with other children, will help a normal child, but the therapeutic value of play to a child in difficulties will come through the medium of interpretation.

The therapist's preoccupation will be with content, with what is being communicated between the therapist and the child. It deserves further discussion.

Interpretation. Medical therapy should, if possible, be specific to the disease, limited to recognized objectives and given in a controllable dose. Interpretation would benefit from a similar discipline. A therapist should never use generalized and stereotyped interpretations that are neither specific to the child's situation, nor directed towards a desired objective; nor should they be applied unless the therapist can foresee the likely magnitude of the effect of the interpretation upon the child.

Most experienced therapists find that not only do they tend to get into grooves in play therapy, but that their patients' play tends to go in fashions. Thus some therapists will find mostly anal erotic or perhaps œdipal genital material to interpret. Therapists are well advised to beware of stereotypy in interpretation; when all brown colour is interpreted as faecal, straight objects as phallic, elliptical objects as female genital symbols and all rivalry situations as unconscious incest, it is time for the therapist to take stock. When almost every child wants to draw, or at another period they all want to play in the sand or with the dolls' house according to sex, such stereotypy will probably be that of the common factor, the therapist, rather than of the children.

Particular care is necessary about interpretations of castration anxiety and its homologues. As remarked in Chapter 12, it is not impossible that the therapist who makes a phallic interpretation of the child's play may be projecting his own genital sexuality into a situation that has more to do with the child's feelings about his more general powers. On the other hand, invariable absence of phallic interpretations might be due to repression on the part of the therapist.

Therefore the therapist needs insight into his own mental mechanisms and also needs to be sure that his interpretations really apply specifically to the situation. A misfired interpretation may not harm the child, but it certainly will not benefit the transference.

Nine principles of interpretation could be advanced:

(1) Interpretation requires the prior establishment of two-way routes of communication with the child.

(2) The therapist must know what is going on at home; he must know the usual family responses to particular forms of the child's behaviour, so that he can tell the significance in the treatment room, of the child's behaviour, and predict how the child may apply the interpretation to his home situation.

(3) The therapist needs an intimate knowledge of the child's past experi-

ences; what they have meant and still mean to the child, so that he can appreciate the full significance of the child's play communications.

(4) The therapist must continuously estimate the state of the child's transference and be especially careful with interpretations when the transference is not positive.

(5) Timing must be accurate, and synchronize with the therapist's movement from one transference role to another. Otherwise valid interpretations may be inadmissible if timing is wrong.

(6) Interpretations must be comprehensible to the child, and acceptable at unconscious levels. An interpretation may derive its force from the role adopted in treatment rather than from the general transference.

(7) The child's immediate reactions to the interpretation must be dealt with before the end of the play session. It is better to miss an opportunity just as the child is leaving to make an interpretation that will cause anxiety, rather than hand an emotionally disturbed child over to the mother.

(8) The therapist must co-ordinate his policy on interpretation, step by step, with whoever is dealing with the mother.

(9) Lastly and most important, the therapist must be equipped well enough by training and experience to be able to foresee and deal with both the immediate and probable remote effects of interpretations.

Although interpretation is not to be taken lightly, on the other hand, unless the therapist is competent to venture some interpretation it will perhaps be better not to start play therapy, which is much more than the skilful handling of children. Often the latter can legitimately be regarded as intuitively applied interpretation, e.g. an overworked nurse in a children's hospital ward may suddenly find that while her mind was on something else a distressed child has flung himself into her arms and is crying on her shoulder. This nurse has intuitively interpreted to the child his need of mothering, but there needs to be more of intent about interpretation in play therapy than merely this. On the other hand, however highly skilled specific interpretation should be, a fetish should not be made of it. Simpler forms of interpretive behaviour in play, sometimes called the 'common sense' handling of children, have their uses, especially by less skilled people, in order to help children to find themselves and to adjust.

Response by activity in play can be just as valid as and may be better interpretation than anything that can be said, e.g. hand pressure on the child's arm, the mimicking of a gesture, a slight change of inflection of the voice, the winning or losing of a competitive game—either obvious to the child or not—or the making of a silly mistake. The therapist can vary the emotional atmosphere so as to expose the child to atmospheres that are important in the child's real life and then relate the child's response to the therapist's role in treatment, which will be variable.

The child's real life attitudes, fears, strivings, dishonesties, jealousies and so

on (not forgetting his loves and strengths) are brought into the play situation and related to the therapist. His worst fears and fantasies, his guiltiest feelings can be contained within the positive transference to the therapist, so that the child will be able to tolerate the necessary modification of instinctual desires and emotional objectives that readjustment will require.

For success the therapist needs to have a flexible attitude, to pay close attention to what the child is doing, and to the state of the relationship with the child. The subtlest therapeutic instrument is manipulation of the atmosphere of the playroom.

Some common situations can be illustrated: e.g. a child may become disturbed by emotional pressure, and it can be a good plan to let him withdraw for a while behind the structured framework of an organized game, or to set the child a task, a picture to paint, and so on. While the child is engaged in a solitary occupation, what the therapist does can be important. Sometimes to read a book or paper, or to write case notes may be supporting and interpreted by the child as a sign of respect—the child and therapist are working together. On the other hand to do this may touch off in the child some reaction relating to home—perhaps to father, whose newspaper-reading after tea must not be interrupted. Then the therapist's action could be a barrier. The child's reaction to such a situation may provide opportunity for useful interpretation, which will be much more effective if it is by design.

A structured game, though often an impenetrable defence, can give opportunities for variation of atmosphere. The game can be played generously, with tolerance of the child's attempts to gain advantages; or in a chiselling spirit; or frankly punitively. To raise anxiety, to undermine the child's security in the transference may, properly interpreted, be therapeutic.

The child's aggressive behaviour will often trouble both clinic and parents. It helps to have the treatment room so constructed that it is impossible for the child to do serious damage. This can be overdone, however, and a room with safety devices, like bars across the windows and grilles covering heating appliances can be unfriendly, even threatening. It is probably better not to have a piece of equipment if tiresome restrictions have to be put on its use. During treatment it is important not to stimulate desires that the child cannot legitimately express without restriction or the criticism implied by prevention. The technical difficulties of this were well illustrated by the experience of a therapist under training, in a third-floor treatment room overlooking a busy street. An inhibited boy was in a critical phase of treatment, in which he was discovering how to express aggression. After an energetic ball game, the therapist opened the window, asked for a rest and invited the boy to paint. Suddenly the boy picked up a pot of scarlet powder paint and threatened to throw it at the therapist, who made a non-committal reply. He impulsively hurled the pot out of the window and it fell upside down on the bowler hat of a passer-by, who was not hurt, but naturally came in to com-

plain. The receptionist was highly alarmed at what she took to be blood all over his shoulders. Happily he was a remarkably understanding man, who did not even send the cleaners' bill to the clinic. In spite of care to protect both the boy and his mother from suffering the unforeseen consequences of his action, the course of his treatment was adversely affected because he found that his impulsiveness had caused anxiety even in the treatment situation. A more experienced therapist might have reacted to the child so as to prevent the happening and thus have avoided a major set-back in treatment.

In principle, no child should be allowed to do damage that costs money to repair, nor any more damage and mess than can be set right by the therapist with or without the child's help, before the next patient's turn. To follow this counsel of perfection requires both experience and good fortune, and how much the child is to be involved in clearing up messes will be part of the therapeutic plan. Tidiness of the treatment room will be a factor of the therapist's personality, but to have a pigsty will not help most children. A middle course can be steered between having an attractive and clean room, and inhibiting the child from making messes and disturbances.

We have seen that when the child's defences have become penetrable in the second phase, material will emerge that can be related to the therapeutic situation, but that his emotional experiences in treatment may tend to upset unstable balances at home; and the danger may be incurred of the parents breaking off treatment prematurely, because they feel that the child is getting worse and not better, as they had hoped.

3. *The Relation of Feelings to the Reality Situation.* The treatment phases are not sharply distinguishable, but the therapist needs to bear them in mind as the treatment goes on. The third phase, the relating of the child's feelings to reality will begin, indirectly, at the outset, through the PSW's work with the mother and, by getting school teachers and others to modify their attitude. More directly in the third phase, the therapeutic pre-occupation will be with *where* the child's communication is going. The change from playroom-centred to environment-centred therapy should be undertaken gradually. In the second phase it will have been possible to interpret to the child that, at a certain moment, he was angry with the therapist and, by relieving his anxiety, to help him to control this feeling. It may be obvious to the therapist that the real object of the child's anger was the mother, with whom he had identified the therapist during the course of therapy; but it can be exceedingly unhelpful to interpret this to the child without preparation. Inhibited children whose hostility is so deeply repressed that they cannot consciously experience their anger will not understand such an interpretation; and may merely identify the therapist with an uncomprehending parent and the transference will suffer accordingly.

Play during the third phase of treatment will help the child to experience appropriate emotions in consciousness, which the therapist will now attempt

to relate to real situations. This should help the child to transfer some of his feelings to their more proper relationship in reality.

Concurrently an attempt should be made to secure some modification of the parental attitude towards the child at home, so that his frustrations there may disturb him less. It may be more difficult to help a mother to do other than promptly suppress her child's hostility, than to help the child to adjust. This will be especially true of many mothers of inhibited children, who may themselves not be able to recall ever entertaining an unkind thought about a relative, having entirely repressed their own angry responses.

When the mother is frankly hostile to her child, the child's recognition of the mother's hostility may impair his ego-strength and he may have a long period of dependence on the therapist before he can fend for himself. Much will depend upon the child finding compensations in his family environment. The father or a sibling may save the situation, and social success in the peer group can be an important asset during late latency and adolescence. Appreciation and progress at school, successful participation in youth activities, can help a child to compensate for a strong feeling of inferiority, except when maternal rejection is severe.

Later in treatment an important objective will be to help both parents and child to withdraw gracefully from their more immature mutual attitudes. Insecure parents may find it difficult to accept that adolescent striving for independence need not be a threat to family solidarity; that, on the contrary, adolescent self-determination is a necessary part of the process of maturation. The greater capacity of the adolescent child, himself, for insight into the situation of others may make the later stages of therapy easier in his case.

TERMINATION OF TREATMENT

It will frequently be difficult to find the right time at which to terminate treatment. The best guides will be the feelings of both child and parents about life at home. If the parent sees that the presenting symptoms have disappeared and not become displaced; if the child appears happy and reasonably confident; and if the mother is genuinely willing to carry on without the clinic, treatment may be terminated safely. The child should be told of the proposed closure some weeks ahead and a policy of tailing off visits, up to monthly and then to occasional check-ups is useful, but it is important not to appear too anxious to keep the child under supervision.

A pronounced tendency of parent or child to cling on to treatment, with a lessened apparent need, will indicate that the dependency has not been adequately resolved; but on the other hand, in less successful cases the problem of closure may be solved through the disaffection of the child or mother, or both. Refusal to attend may be indirectly expressed by allowing difficulties, such as a long journey, inconvenient hours, expense or missing school, obstacles that were cheerfully overcome at first, to become reasons for not

attending. It is usually pointless, and often unwise, to insist on continuing, except in the case of the punitive mother or father who has brought the child to the clinic for a cure of a tiresome symptom. With fantasies of nasty medicine or painful correction in their minds, such parents may be badly put out if their child enjoys treatment. Their jealous hostility may be aroused should they realize that the child prefers the clinic to home, and if appropriate therapy cannot be applied directly to the parent, the case will probably fail. Failure in such a case may be tragic, because of the child's unusually great need for protection.

SOME PRACTICAL CONSIDERATIONS

If long delay between diagnosis and treatment is unavoidable, letters, telephone conversations or occasional visits will help to demonstrate the clinic's continuing concern. Adequate notice should be given of the first treatment visit, and arrangements should, if possible, allow children with commitments to attend at the best times for themselves. Any extraneous source of stress is unhelpful in treatment and a compromise needs to be effected between adherence to an appointments system and giving an impression of rigidity or of being too busy for the individual child.

The material conditions of the clinic are usually determined by factors outside the therapist's control, but if a choice be possible, an ordinary type of house appropriate to the district is better than either a modern ferro-concrete, super-hygienic, functional hospital building, or old-fashioned local authority, glazed tiled, reproduction gothic. A primary consideration is to make the child feel at home and every member of the clinic staff should realize his or her role in this. All must show unfailing courtesy to and understanding of the child, however tiresome, for it is vital to the child's treatment for him to be able to express his tiresomeness in the clinic.

A treatment room that is too small for the child to be able to get into a corner and feel he can escape from the therapist will not be convenient for psychotherapy. Furnishings will be the better for being familiar to the child, and should range from small tables and chairs for the tinies, and a comfortable chair for the adolescent. One table is needed to take hammering and driven nails without anyone complaining; large flat surfaces are needed for painting; and a hard gloss paint on the wall will make murals possible. Running water should be laid on to a flat shallow trough at a small child's height, with an impermeable floor surround. Toys are best kept in open cupboards but two locked cupboards will be needed, one for the therapist's treasures and another in which children may keep their unfinished work. The play equipment should consist of articles that any middle-class child might expect to have at home with, in addition, two sand trays—for wet and dry sand respectively. Wood, metal and plastic figures of human beings of assorted shapes, sizes and races, domestic and wild animals; and bricks and constructional material,

dolls' furniture, tea sets and so on, will be required. Dolls' houses should be of simple design and strong; and home-making materials, cooking sets, dolls' dresses and bedding will be useful, and sturdy mechanical toys of simple design. The wear and tear on toys is heavy, and old wrecks will make some children anxious. Ample supplies of paper are needed; pencils, crayons, chalks, paints and modelling clay; anything is legitimate with which the therapist can get a response from children.

Pre-school children will need a nursery type of equipment; they need playing with in the simplest type of family atmosphere. Often they will need to find out *how* to play, and little else may need doing. The really important work here will be done in modifying the mother's attitude and handling of the child at home.

School-age children need a wide range of play material. Many therapists find the Lowenfeldt 'World' material useful with junior schoolchildren. Others will use drawing, painting, modelling, puppetry, mechanical construction, dolls' clothes-making and other constructive activity. Older children take easily to board games, competitions, puzzles and so on. As we have seen, the children's play will relate to the therapist's own capacities and interests; and the educational bearing of the material used must be borne in mind. Also, junior schoolchildren will have important needs for physical activity.

With adolescents, respect must be paid to their growing sense of maturity and dignity by explaining that the toys are for the use of the younger children. Most adolescents will respond to conversation, discussion and abreaction, but many will be helped by expression in drawing, painting, making up stories and plays and so on, provided that the intellectual and technical content of the activity is adequate. It calls for aptitude in the therapist to use these media satisfactorily.

Activities therapy will be limited by equipment problems, it requires a workshop, and also technical knowledge. The therapist's willingness to learn alongside the adolescent may help.

Many therapists advocate the use of 'aggression' rooms and 'dirty' rooms so constructed that the child can be as destructive, regressed and degraded as he likes without incurring criticism. Other therapists will object to this idea because of its symbolization of repression, in that unacceptable impulses will be relegated to expression only under rigidly controlled circumstances and are excluded from the general stream of life.

OTHER TYPES OF TREATMENT

Supportive Treatment. In certain cases it is useful for the family to make occasional visits to the clinic for reassurance, encouragement and support. This is particularly true of the behaviour difficulties of young children, when mothers will bring their toddlers along, say, month by month, to discuss the

day-to-day handling of the child. Sometimes the process of investigation and diagnosis alone will have enabled the parents to arrive at a greater understanding of their difficulties, and reattendance a few weeks later, to reassess the situation will clinch the issue. Older children can advantageously attend alone, if the parents have the necessary trust to permit this. The common factor in the selection of these cases will be evidence of spontaneous tendencies towards amelioration or cure.

Group Therapy. Group therapy is not highly developed in child guidance, due mainly to practical difficulties. Case selection is a major problem. If the group includes only a narrow range of ages, the issues will be simplified. Pre-school boys and girls are best taken together, but in the case of latency children, there are cogent arguments for segregating the sexes. The interests of boys differ from those of girls, and most children are more used to working out their problems among their own sex. On the other hand, segregation will deprive members of valuable experience. In an adolescent group, the mixing of the sexes will add to the group their most pressing general problem, in addition to their specific problems for which they are seeking help.

What types of children should be taken? How many out-turning and aggressive children should be mixed with how many timid, retiring, in-turning or inhibited children? With aggressive children only in a group, there will be hell; and with inhibited children only, nothing! It is also important to avoid the risk of adding social failure in the therapeutic group to the burdens of a child who has already been a social failure in school.

What does the group do? Pre-school children are accustomed to play with nursery material; but latency children need space, facilities to make a noise, to enter into gang activities, including warfare. Adolescent groups are even more difficult to occupy, because their activities need to be at an adequate technical level. Few clinics can provide well-equipped workrooms where boys and girls can pursue their interests at a suitable level of technical proficiency.

Group supervision is a difficult problem. Even with a small group of four children the therapist cannot keep a real watch on each child, and valuable opportunities for interpretation may be missed. An additional difficulty is that a complete group of younger children will rarely attend on two successive weeks. Almost always one, at least, will have a cold or an infectious disease, or the mother will be ill, or taking a sibling to hospital, and so on. Intermittent attendance will prevent the group from functioning as such.

Activities Therapy. Organization problems and excessive cost make activities therapy difficult to provide. Well equipped workshops will be needed for creative work in painting in water colours and oils; clay modelling; sculpting, pottery, various forms of designing, woodwork, metalwork, model building, photography, etc. Activities will be better with a skilled instructor and

should be engaged in either by the child on his own, or in groups of two or three, in conjunction with or as an adjuvant to psychotherapy.

Physiotherapy and Eurythmics. For those children who have difficulties in motor control and in orientation in movement and space, suitable help with movements and medical gymnastics generally, can be important. The objective will be for children to acquire confidence in the use of the body. Children with mild handicaps of a spastic and mid-brain type will be particularly suitable for this approach, as also will those inhibited children who have never been able to trust themselves in free motor expression. It requires skill to encourage the child through success, instead of the discouragement that they have had through their clumsiness and inadequacy in the school gymnasium and in free play. Also, some children with primitive orientation difficulties who have a tendency towards recovery through cognitive reorganization may benefit from experience of pleasurable bodily activities (see Michael L. (5), Tim T. (36), and James L. (37)).

Therapeutic Day Nursery. A therapeutic day nursery for pre-school children offers considerable possibilities, but expense and accommodation difficulties have prevented the development of this idea. This form of treatment is particularly suitable for mother-fixated children who have difficulty in moving through the oedipal phase of development. A group will consist of about six children meeting daily from about 10 a.m. to about 3 p.m. five times a week. The therapist needs to have nursery school experience. Treatment is effected through the group situation and by some interpretation. Individual therapy can be given as necessary. The midday meal, followed by a rest and relaxation period will give some of the best opportunities for interpretation and for getting to know the children.

Parents of these children will normally have regular interviews with the PSW themselves and in the case of some, mothers will have to be allowed to bring their children in the mornings and remain part or all of the day. This may cause troubles, for obvious reasons.

The therapeutic day nursery is also applicable to groups of children suffering from difficulties in orientation in personal and social relationships (see Chapters 7 and 9). These children, however, may require almost individual handling, which will make the group unwieldy. A prolonged and intensive relationship with the therapist can be supplied by a judicious mixture of group and individual treatment in a nursery environment.

The Therapeutic School. The special day school like the therapeutic day nursery has been little used because of organization difficulties. Such a school should be organized in classes of, say 8 latency children, who should not be too disparate educationally, and it requires great qualities of skill and patience on the part of the teacher.

A therapeutic day school is incomplete without facilities for individual therapy and for group activities, which require space and organization.

Residential Treatment. This big subject deserves discussion on its own. Some clinics are associated with a residential treatment home or with an in-patient ward. The latter needs to be equipped for reasonably long stay, and it is necessary to provide a complete life for the children, a difficult undertaking, with big implications for the children's families.

The in-patient ward has only limited usefulness as an observation centre, for observation of children in an artificial environment will give little information about family relationships. Wards are also useful for temporary admission in order to relieve an impossible situation at home; but it is essential that any admission must include a constructive plan for the return of the child to his own home.

Unfortunately the usefulness of the few in-patient wards for disturbed children that exist in Great Britain is sadly reduced by waiting lists of such length that vacancies are not freely available in a crisis and, in addition, little attempt is made to provide a complete therapeutic life for their children.

The provision of psychiatric consultant services to children's hospitals and residential homes is another order of undertaking, of great and growing usefulness.

Treatment of Parents. Parents will sometimes say that it is they who need treatment rather than the child; commonly an insincere remark, but it is occasionally true. It is usually better for the parent to go elsewhere for personal treatment, but the clinic can, if desired, support the child during the parent's treatment. In other cases, the price of the parents' co-operation may be the child's attendance also, and a 'caretaker' group can be arranged to give the child experience of group life, in a normal atmosphere without a specific therapeutic aim.

Martin B.'s (57) case is an example of both mother and child attending for psychotherapy (see also below). *Simon L.* (20) attended a 'caretaker' group. Simon's mother's massive sexual guilt had been projected on to her boy and she unconsciously provoked him into aggressive behaviour, which neither could control. Her treatment included much abreaction and she took a long time to work through her use of the treatment sessions as an equivalent of an incestuous sexual relationship with a father figure. Eventually the resulting improvement in family relationships enabled Simon's development to continue with less emotional distortion.

CERTAIN SPECIFIC CONDITIONS

The difficulties of the habit-forming period of early childhood deserve separate mention. The objective of treatment will be the resolution of family

difficulties and the increasing of the mother's competence. In all these cases, a detailed history and an adequate physical examination of the child are important.

FEEDING DIFFICULTIES

The child who will not eat is a tremendous threat to the mother, at a primitive level. If the maternal anxiety can be eased, the feeding difficulty will commonly lessen. When, as is common, the cause of the trouble is the mother's rejection of the child, treatment is likely to prove wearisome, for the mother will pull against the therapist in many ways. Simple reassurance will not be enough; but more can be done by regular counselling with the mother, week by week, talking over the difficulties. The mother will be encouraged by the seriousness of effort which is made to discuss the details of the problem. One paradoxical way of achieving some slight success will be for the therapist to get enough transference for the mother to project on to him the blame for the child's continued failure to feed, though she is following the therapist's advice. This canalization of the mother's hostility may relieve the anxiety surrounding the child, and the resulting slight improvement in the child's symptoms may, in turn, enable the mother to readjust.

Mothers are far too anxious to follow the common advice—not to worry but to put attractive food in front of the child without comment, to remove it after a certain lapse of time if uneaten, and to stop snacks between regular meals. The mother's unconscious hostility may be revealed in resistance to suggestions that the child be given sweets and odds and ends as he wants them, a resistance that is rationalized in the fear of spoiling his already non-existent appetite.

SLEEPING DIFFICULTIES

Sleeping difficulties probably owe something to a constitutional element, in the case of some hyperkinetic, very out-turning babies who sleep little from early infancy and who may provoke a strong anxiety reaction in the mother. The very tenseness of the mother's handling of her child at night may be the greatest preventive of sound sleep. The main treatment task will be to allay maternal anxiety, especially about the damage done by loss of sleep. Unfortunately the forebrain depressant hypnotic drugs will not affect the sleep disturbances of young children that are due to midbrain hyperactivity. Antihistaminics often will give better results than barbiturates or chloral. Amphetamine will sometimes have a paradoxical calming effect in the case of severely retarded but hyperkinetic children and poorly oriented children who show stereotyped overactivity, e.g. *Phyllis B.* (34) and *Suzanne B.* (35). The stimulation of cortical action appears to achieve a slight degree of control of lower brain centre activity.

TOILET TRAINING DIFFICULTIES

The major obstacles to successful treatment will be the parental reaction to the difficulty and the child's defensive response. The ætiology of difficulties over toilet training is diverse and in the case of younger children, the main need will be to secure a general improvement in the mother-child relationship. It is important to bear in mind the mother's level of aspiration in regard to toilet training. For example, some mothers do not really expect their child to be clean; perhaps other members of the family have been troublesome in this regard, or the mother is a depressive person who expects little from life. Some mothers fail to get their children to understand that they ought to become clean and dry.

ENURESIS

It has been repeatedly stated that enuresis has a diverse ætiology. Apart from rare congenital physical anomalies and slightly less rare neurological disorders, it is generally true that failure to gain bladder control at the appropriate age will have been due to an emotional reaction. But by the time the child is presented for treatment, the cause may have disappeared and the symptom maintained by habit which, however, may have secondary effects, both structurally and upon character formation.

Three important emotional causes of enuresis are:

1. The breakdown of premature pot training at the end of the first year resulting in the child's counter-reaction to a hostile maternal attitude;
2. Interruption or impairment of mother-child relationships during the process of toilet training, whether resulting from separation or from maternal hostility or indifference.
3. Breakdown in newly formed clean habits, often due to a sudden impairment of mother-child-relationship, causing regression.

It is unusual for the emotional cause of enuresis to remain long at a high pitch of intensity, but continued wetting cannot fail to decrease mutual esteem, the mother's aspirations suffer and the child's ego-strength is weakened. The resulting lack of confidence in both parties in the child's ability to become dry, will be the therapeutic problem.

As far as nocturnal enuresis is concerned, a few children have small and hypertonic bladders that will not hold sufficient urine to last the night. This is difficult to treat, but exercises to give the child greater control over micturition may increase confidence, which together with more general boosting of the child's morale, may lead to success.

Pre-School Children. If the mother is able to be objective and supporting rather than discouraged and punitive, it is worth getting her to retrace the steps of the training process, if possible. The mother should get the child to use the pot last thing at night and put him to bed with encouraging remarks

about his ability to be dry in the morning. If she lifts him during the night, it is best to wake him, so that he is aware of what is going on. The child's refusal to be got out of bed is a sign that the mother is unable to handle the situation sufficiently constructively. The occasional dry night should be modestly rewarded. With a patient and constructive attitude a high proportion of under fives will be cured quite quickly.

Some mothers' neurotic attitude to bedwetting will result in their disgust and chagrin merely heightening the child's anxiety when they attempt to deal with the trouble. Contrariwise, the mother who is careful never to mention bedwetting to the child for fear of upsetting him may impair the latter's system of values and capacity for growing up.

Schoolchildren. Current methods of treating nocturnal enuresis in the 6-12 age group are unsatisfactory. Genuine willingness to try and some inkling of belief that a cure may be possible are essential for success, and latency children are often far too discouraged to make even the slightest attempt. Their neurotic defences will include refusal to be serious about it; very heavy sleep that prevents waking up; an angry denial of the trouble; or a devil-may-care attitude of lack of concern. Although the child probably does not exist who genuinely does not care about bedwetting, in the face of any such attitudes, direct therapy is hardly worth undertaking until later. On the other hand, many latency children will respond markedly to general measures to increase their social competence and, with greater success in school and in peer group activities, bedwetting will frequently clear up *pari passu* with the general improvement, even if direct treatment proves unrewarding.

Adolescents. With the onset of adolescence, many bedwetting children will develop strong desires to gain relief from the condition and in their case the therapeutic climate will become favourable. This has resulted in a multiplicity of so-called 'cures', most of which depend upon reassurance. Suitable explanation of the cause, an assurance that they are neither alone in their difficulty nor is their trouble incurable, an offer of constructive help, signs of continued respect and a demonstration of taking their trouble seriously will evoke a response in most pubertal children.

There are many practical ways of boosting the child's confidence, for example, exercises to gain greater control can include the starting and stopping of micturition, and holding water until discomfort is felt. The main benefit is probably subjective. Sleep can be lightened to the degree of waking once or twice a night, but the child's willingness to get out of bed and empty the bladder is an important test of motivation. Amphetamine is useful if given at the very last moment at night, so as not to prevent the child getting off to sleep, and if the child is able to control and administer his own medication. Amphetamine needs very heavy doses; commonly a 14-year-old will take up to 20 mg. per night without affecting sleep.

Some adolescents will be helped by pituitary extract to delay kidney action and thus to give a better chance of remaining dry until morning. Dispidin can be given by insufflation in 1 or 2 grain doses. The child should attend regularly for checking results and for encouragement. Some children will get satisfaction from keeping a record of dry nights on a calendar and this enables the therapist to draw attention to a pattern of improvement. A small minority of cases, boys rather than girls, will be too deeply neurotic to face the implications of growing up. Sometimes relief can be gained through psychotherapy of an analytical type, which may help the patient to resolve his strong inferiority feeling and probable castration anxiety.

In addition there are two forms of electrical apparatus designed to treat enuresis by conditioned reflex methods. Both depend upon electrical contact by the wetting of an electrode. In one type a buzzer wakes the patient at the very moment of wetting and it is hoped that the surprise will inhibit micturition. This method is susceptible to a neurotic defence by heavy sleeping that is unaffected by the buzzer however loud. Some children will rouse but continue wetting. Another apparatus gives a shock through an electrode attached to the abdomen or thigh, strong enough to be unpleasant. It effectively wakes the patient, and apparently will condition a reflex waking, immediately before wetting would have taken place. Everything will then hinge upon the child's co-operation in getting out of bed and emptying the bladder. In successful cases, within a period of about one month or 6 weeks it will be found that the child will sleep through the night without waking. It appears that relapses are not common. It is likely that the secondary gain from cure will be the decisive factor and this method of conditioning will be useful in those cases in which the bedwetting continues as a habit and is not a result of continuing conflict or instinctual dissatisfaction.

STAMMERING

Finally, the briefest of mention of the common and distressing symptom of stammering: in principle the treatment of stammering will be that of its underlying disorder of the control and expression of aggression. However, stammering will often continue as a faulty habit pattern long after any causal neurotic conflicts have disappeared, and then it is reasonable to employ the conditioning methods of speech therapy, or disinhibition by making the subject talk against opposition. When stresses and strains exist over the control and utilization of aggression, when there is excitability, over-inhibition or periodic loss of control, and so on, the underlying emotional problems must be treated.

SOME ILLUSTRATIONS FROM TREATMENT CASES

The reader is referred to the text above for a full description of the children whose treatment records are briefly extracted below.

A GENERAL OUT-TURNING AND AGGRESSIVE SECOND-YEAR REACTION

Martin B. (57)

Martin, who was so much at the mercy of his feelings, was a slow starter and refused to leave his mother at the first treatment visit. During his first four visits he vigorously protested against each new experience and disliked handling dirty objects. He was visibly shocked by the sight of broken toys.

He took a hammer, saying that he wanted to smash something big, and hammered at a brick lying in the yard. So far his neurotic defences were holding strongly but during the fourth interview he relaxed a little. He referred to a dolls' cot, saying that Linda (his sister) had a cot like it. A little later he hit the cot with the hammer, and this was interpreted to him as wanting to smash something, and something suitable was suggested. He repeated: 'I want to smash something big.' A few moments later he hit the dolls' cot with a toy spade, but the obvious interpretation was withheld, because it was judged to be not yet safe to make.

During this phase he had gone scrappily from object to object, poking into corners; starting and stopping: intermittently cutting plasticine into cubes and flattening them with the hammer. His strong aggressive impulses seemed indirectly concerned with his father (smash something big) and Linda, whose cot he symbolically demolished several times.

Illness interrupted treatment for 2 weeks, after which Martin was tenser and stammered. During two visits he recapitulated his exploratory play, with thinly disguised destruction of members of his family. The pattern of his play consolidated, for example he would assemble the toy railway and suddenly tear it apart again; he would put animals in the sand tray and then bury them, excitedly. After excitement he would suffer a reaction and attempt to gain compensation by wheedling a sweet out of the therapist, or try to take toys home with him, as keepsakes. These incidents were interpreted to him in relation to his play.

By about his twelfth visit Martin knew exactly how much aggressiveness and destruction was appropriate while in the clinic. His anxiety following 'bad' behaviour had abated and he was well into the second phase of treatment.

The therapist then began to withdraw his protection from Martin's aggressiveness. Martin reacted with anxiety while in the clinic, but his behaviour at home remained less disturbed. At the thirteenth visit Martin was excited though, on the surface, friendly. After some scrappy play he modelled in plasticine a house and four human figures, two large and two small, which he sat on the roof of the house. He agreed that these represented the family. He turned away and bounced a ball against the wall, humming a tune, and then surreptitiously removed the roof of the house and popped one of the smaller figures inside, replacing the roof, but setting the three other figures on the table. He bounced the ball again, still humming. Suddenly he picked up the hammer, rushed across the room shouting loudly, and flattened the house in an orgy of destruction, and then went back to the ball. The therapist quietly murmured: 'Poor old Linda'. As if he had been stung, Martin rushed across the room again, scraped up the plasticine and threw it out of the window, shouting loudly. He then fiddled with some toys aimlessly and, unusually for him, sidled across the room, climbed on the therapist's knee and asked to be read to. This was verbally interpreted as getting rid of Linda, and a liberal amount

of physical reassurance was given. He was subdued when he left, but he evidently gained adequate reassurance because at the next visit he showed no anxiety at returning to the scene. This was the only occasion when Martin showed his feelings directly. During the next 3 months his play became more constructive, punctuated by short spells of violence for which he demanded reassurance, and he continued to take toys home.

Meanwhile his mother's treatment continued, and his father's co-operation was secured more realistically, in that he began to support Martin more effectively, so that the latter was allowed to experience his feelings with fewer arbitrary restrictions. When treatment was terminated after some 25 attendances, Martin was experiencing the greater part of his feelings in consciousness; and only occasionally was becoming too anxious to be able to control himself. He had a long way to go before he would be able to express his aggression smoothly and without danger of loss of control, but with the improved family atmosphere the prognosis appeared to be good.

AN ŒDIPUS SITUATION WITH ANXIETY AND INHIBITION

Gerald D. (67)

At the beginning of treatment, Gerald was as inhibited as could be imagined. At his first treatment session he played with a toy train in complete silence except for one remark in a still, small voice.

His play was imaginative; during his second session another boy rushed in and 'shot' both occupants of the playroom. Gerald immediately telephoned WHI 1212 on the toy telephone and had the boy arrested. Encouraged, he later telephoned the therapist and ordered several improvements to the toy railway. At his third visit Gerald drew a caricature of the therapist whose face was purple with rage because he (Gerald) had called him by his surname. The therapist was clothed in Gerald's school tie and belt; and having established some identification with the therapist, Gerald responded vigorously in a competition to shoot down lead soldiers.

At the fourth session he evolved an elaborate ritual of shooting soldiers in two rival armies, though with extreme care not to damage any toy, and also fantasied shooting out of the window. He initiated the construction of two forts manned with toy soldiers and fought a gun battle, with excitement but with carefully controlled destructiveness. This formal warfare continued for 5 or 6 weeks with increasing noise and some abusiveness. This episode culminated in his horrified mother overhearing him shouting a very slightly rude rhyme on the therapist's name. Her reaction in private at home caused Gerald to retreat at the Clinic into games like Ludo, Snakes and Ladders and Draughts, which he played with concentration and enthusiasm, accepting defeat gracefully.

Four weeks later he ventured back to the shooting game and then playfully threatened to throw plasticine at the therapist. On being dared to do so he carefully missed, but the therapist replied unskilfully and accidentally hit him in the eye. Gerald collapsed into tears and in spite of much comforting was subdued on leaving. Before his next visit, his mother came in, too, and said that he had collapsed on the way to the clinic, but had recovered. When she had left, Gerald growled: 'I didn't collapse.' He added resentfully that his mother was always making a fuss over him.

He continued very excited during this visit and his mother upset him again, remarking as they left: 'I think you two have a fine time together.'

His play continued rather subdued, with occasional excitement, for 4 weeks, when he accidentally spilled water on the floor. He then deliberately spilled more and when the therapist protested at having to clear it up, Gerald became quite wild, but he refused to go until he had helped to clear up. Asked if he ever made a mess at home, he replied: 'No fear, soon get told off if I do.'

Gerald's aggressive, even hostile, behaviour continued tempered with dependent gestures such as getting the therapist to button his coat for him. One day he was subdued and explained that he had been forbidden to go into the garden because he dirtied his clothes. His choosing Snakes and Ladders was interpreted as a defence against the possibility of disobeying his mother. He replied, picking up a ball of plasticine: 'I'm going to throw this at your ugly face; I'm going to biff your dial.' This was interpreted as displacement of resentment against his mother.

His aggressiveness increased to the extent of punching the therapist, but not very hard; and remarks like: 'Hullo, funny face; hullo my old cock sparrow; hullo you cock sparrow cum twerp.' Once he said: 'I'd like to chuck this phone at you, I know you're soppy', then accepted a sweet and ate it greedily. He never went 'too far' in his aggression; and frequently would make amends by patently allowing himself to be beaten in board games. Interpretations were made in terms of his feelings, his fantasies of the therapist's reactions and, progressively, in relation to his parents and cousin when it appeared that he was moving into the third phase.

After a missed appointment due to the therapist's influenza, Gerald was particularly cruel and hard; and a fortnight later still, after another interruption, he burst into the room yelling: 'Did you know that you ought to have your silly old dial bashed in.' His repeated assaults were interpreted as a displacement of his wish to hit his mother; and he replied: 'I *do* hit her, often.' At the end of this session he was particularly unwilling to leave.

After about the twenty-fifth attendance, Gerald began more constructive play in the sand tray. He tunnelled under a sand castle and buried some dolls' mugs saying: 'We must bury them very deep so they can't be found.' He accidentally uncovered one mug and put it back excitedly, fired a gun into the hole and shouted: 'We must stop it from coming out, nobody must know what's there.' He refused to help clear up the mess but did not want to leave. Next time he made an appalling mess, but cheerfully volunteered to make it tidy and went away happy. His play became more robust and less arbitrarily cruel. Two months after deliberately kicking a ball next door, he was excited at making amends by finding another.

In the summer Gerald played cricket in the garden, quite generously, and was good-temperedly aggressive. Once when he accidentally threw sand in the face of the therapist he collapsed on the floor, ostensibly laughing, but very anxious. He immediately wanted to play cricket in the rain, disobeying his mother's orders, recovered his nerve and left on an easy note. Another time, he accidentally dropped the therapist's travelling clock and was most upset. He denied liability and became aggressive, once again unable to control his feelings. The therapist failed to cope with these feelings and Gerald's disturbance continued in the next session when, as described on page 425, he knocked the therapist over and sat on his chest.

Gerald's aggressive behaviour was frequently interpreted in terms of his feelings

towards his parents but even at the fortieth interview he was still not quite able to stand the anxiety of being aggressive. He dared the therapist to throw a ball at him across the garden; but the therapist proved a better marksman than either of them expected, and Gerald was able to laugh it off. However, he became exceptionally noisy and would not stay in the room with the therapist with the door shut. This, he agreed, was because of his fear of what the therapist might do to him. However, when his mother, attracted by the noise, looked in he shouted: 'Coo! What are you poking your nose in here for?'

At the next visit he was disturbed by the therapist's cold and shouted to his mother on leaving: 'That cad's got a cold. He can't cure himself, so he can't be much good.' Next time he was quieter and friendlier. He refused iodine for a graze on his knee and said: 'What do you take me for, I'm not a silly twit.' Next week when he accidentally hit the therapist in the face with the ball, he pretended that the ball was lost. He hesitantly denied the interpretation but it cleared up the matter.

During the next week he quarrelled with a friend at school and suffered some transient regression. He reverted to sand and water play, cheated at cricket, was upset at meeting a girl in the corridor and was strangely terrified when he sat on a swing.

During the remainder of that summer, his play became progressively more constructive, with fewer relapses into aggression and abusiveness, and less anxiety. He also began to show the high quality of his mind at school.

Mrs. D. had also made great progress towards containing her own anxiety and modifying her behaviour with Gerald and her husband. The outbreak of war and evacuation terminated Gerald's treatment abruptly at a time when termination was beginning to be foreseen. Gerald was evacuated with his mother for a few weeks, and one year later, in 1940, was re-evacuated with his school, his parents temporarily going to live nearby. When they returned to London one year later still, he remained with the school.

Unhappily, both parents were killed in an air raid. Gerald was adopted by his mother's brother, and he adjusted well. Gerald duly passed into grammar school, did very well, gained a commission in the infantry during his National Service and when last heard of, was studying for an Engineering degree at Cambridge.

It may be claimed that this satisfactory outcome would have been impossible without the resolution of his difficulties over the expression and control of aggression and of his Oedipus fixation, through psychotherapy at the age of 7 years. It will be noted that, though the treatment phases were intermingled to some extent, great care was taken early on not to make interpretations until their value could be judged, and that only *ad hoc* material was used in interpretations.

FATHER DESERTION

The Roberts Family (91)

The Roberts brothers had been exposed to the same stress, but at different ages. George, who was 9 at the time of the desertion of his father, had had an incomplete resolution of an earlier oedipal difficulty. He was an in-turning but rather inhibited boy of high intelligence, who showed psychosomatic stress signs—bronchitis and asthma, regressive behaviour, and rejection of school.

Ten year old George was a slow starter, he was self deprecating and talked only about unimportant matters. During six sessions he painted copies obsessively and had some pedestrian sand tray play. At the third session he started baby talk as a joke and continued with some satisfaction. There was rather a bad outbreak of stealing from his mother, whose reaction was difficult to control. He was openly jealous of Henry and, although he did not criticize his father, he was frankly hurt about the latter's defection.

During the second 3 months of weekly treatment George brought along many electrical gadgets—a buzzer, a morse code transmitter, and so on. He was very dependent upon technical assistance, and otherwise his play was aimless. He was babyish in patches and became excited over trivialities. One day he put a match to some pencil shavings in an ash tray, but only after much encouragement. He was almost uncontrollably excited; and he repeated the little ritual for several weeks.

George's behaviour at home was less worrying, but he had a blinking tic when in trouble. His play was too regressed to give early opportunities for interpretation.

After 20 interviews the therapist began withdrawing support, refusing approval, and interpreting. George became more animated, baby talk disappeared and he talked about his feelings.

An educational crisis intervened. He failed the 11+ exam but educationally and socially, grammar school education was indicated. After consideration of his educational needs and his female domination at home, he was ascertained as maladjusted under Section 34 of the Education Act 1944 and sent to a residential grammar school for maladjusted children, where psychotherapy was continued. This was a success, except for his backwardness in basic school subjects; his chaotic spelling resisted all remedial measures. Psychotherapy helped him to adjust eventually to the loss of his father but he remained rigid, with over-strong super-ego formation. With a struggle he managed to reach university level in science.

Henry suffered his father's defection at the age of 3 years, but 6 years elapsed before psychotherapy was started. At 9 Henry was at an early level of Oedipus fixation, with uncontrolled turbulent feelings and an urgency to gain satisfactions, which led to serious stealing.

Two years of remedial teaching had helped Henry a little and, though less intelligent than George, his school difficulties were also less severe. Henry's near hypomania made him very active during therapy. He invented various forms of football and cricket suitable for two people in a small room; he verbalized his difficulties easily. Unlike George, he abreacted about his father; he was hurt, puzzled and angry. He had little fantasy but needed masculine contact. The headmaster of his junior school, who showed him warmth and understanding lacking in the acidulated headmistress of his infants' school, gained an immediate response in Henry's increased educability.

Henry's treatment proceeded with active games, some regressed sand and water play, and much talk about neutral things. His neurotic defences were weak; he easily experienced his feelings in treatment, but related them to reality only with difficulty. His father's continuing to live in a road that lay on Henry's direct route to school proved a great difficulty and he nursed a passionate belief in the possibility of reconciliation. He displaced much of his positive feeling for his father on to George and stubbornly resisted being told that he could not go to George's school. After 2

years of rather intermittent psychotherapy he adjusted happily to the boarding house of a small country grammar school, with a normal but strongly masculine atmosphere.

Henry's treatment included rather little explicit interpretation; and its success, like that of George's treatment, owed much to his mother's ability to use constructively her own sessions with the PSW which continued intermittently over the whole period of treatment of the two boys. Her supportive and non-demanding attitude helped both boys to weather a very bad storm.

AN IN-TURNING AND INHIBITED SECOND-YEAR REACTION

Derek G. (58)

Derek had extremely strong neurotic defences and much of his year's treatment was devoted to the first two phases. Early on he illustrated his concept of himself in an obsessional painting of a big (mother) house, and a little replica (himself) by its side. At first he withdrew into introverted play in the sand tray, but with careful interpretation he slowly displayed in the play room something of his repressed aggressiveness.

Derek's bedwetting, though shameful to him, was the strongest of his neurotic defences against moving on from his mother fixation. Playing board games and doing a big jig-saw puzzle with the therapist represented an advance into more grown-up attitudes. To the strength that he derived from this co-operative behaviour he added some magical thinking. The jig-saw became a talisman—he fantasied that when the jig-saw was completed he would be clear of his bedwetting. The puzzle progressed very slowly, but the talisman worked.

In Derek's case much direct interpretation was given of the value of bedwetting to him, its aggressiveness against his mother, and so on. Mrs. G.'s co-operation contributed much to success, and even withstood Derek's failure to gain grammar school entrance. His father and brother also faced some home truths with courage.

As often happens in cases of enuresis, Derek's gain in ego-strength from the cessation of the symptom which shamed him, strongly reinforced his improvement in other troubles, and the eventual outcome appeared to be favourable.

A WEANING PROBLEM AND OEDIPUS FIXATION

Rodney H. (60)

Rodney's mother fixation and feminine identification had escaped notice until he went to a junior school; and his neurotic defences were so strong that for the first 6 weeks of treatment he would only sit and talk about his weekends spent fishing with his parents. He was nine years old at the time.

At his seventh visit he set some soldiers in the sand tray to fight against a hidden enemy. Then he buried the soldiers deeply in the sand and vaguely shot at them, and then carefully put them away. His next two visits were spent entirely in typing his name and address.

After a 6-weeks' summer break his play developed as if he had suddenly discovered how to play. He was a *deus ex machina* in a sand tray fantasy of speed cops caught in a sandstorm. The following week he altered a 'Do not touch' notice left

by another boy into 'You can touch this as much as you like'. He even laughed as he related how his father had lost his catch of fish and nearly fallen in the water.

After a slow start he passed rapidly through the second phase of treatment. Sand tray fantasies alternated with typing and doing puzzles with the therapist. His attitude to school had become transformed. He showed occasional regression under maternal pressure, and on the whole was still passive with his parents. He showed resistance to treatment when interpretation was too advanced and when it concerned masculinity. 'Do I have to come? It makes me miss school and school is super.' This was a remarkable change from the boy who, 6 months earlier, had come running home from school crying that he could hear the other boys running after him.

At his last treatment session he built a fort in the sand tray and set a number of cowboys to fight a solitary Indian. The latter won; he gloated and said: 'Fancy, that Indian beat all them cowboys.' In such an over-good child, this reversal of the more usual identification was interesting.

His mother's capacity to change her ways was so limited, that treatment terminated with the alleviation of the pressing problems. Rodney's competence would carry him forward at a pace his parents could tolerate.

A PSYCHOSOMATIC LATENCY PROBLEM

Stephen N. (76)

Eleven year old Stephen appeared to regard life from the sideline. At his first treatment visit he talked freely and was very friendly. He played tentatively with Dinkie toys in the sand tray, with a superior, big boy attitude, but gradually getting interested. He laid out a village street and drew the therapist's attention to the overwhelming presence of what he termed 'the forces of law and order'. This dilettante attitude prevailed for more than ten visits; he played with ideas but remained outside them, and there was nothing that could bear interpretation. At the twelfth visit he was amused by a leaflet describing a film entitled 'Feeling of Hostility' and said: 'I often have a feeling of hostility towards Michael.' This was so obvious as not to need interpretation.

His migrainous headaches became infrequent, and it seemed that his dilettante attitude was a relic of inhibition. His humour was quick and warm. Picking up a broken stump of a lead palm tree, he remarked: 'Looks like somebody's been pruning this.'

At the fifteenth interview he gained a good deal of release by talking about teasing his parents. He then brought his remote control car and developed some highly intricate and technical competitions in steering this. At last he had become wholeheartedly involved in something that he found difficult, and this experience appeared to give him confidence to tackle other difficult tasks, including his school work. His headaches disappeared. Little more was attempted than to consolidate this advance. In due course of time Stephen passed into a grammar school and when last heard of was an undergraduate in economics; apparently fit and happy.

A FIRST-YEAR PSYCHOSOMATIC REACTION PATTERN

Hilda N. (43)

Hilda's mother did not believe in her, and Hilda's overwhelming problem was how

to believe in herself. Eleven year old Hilda was the slowest starter imaginable. She volunteered nothing and if allowed to would sit quite still, indefinitely. It was even feared that she might be suffering from schizophrenia. On one subject only—horse riding—would she become animated.

Chess proved her salvation, and during a year of treatment much interrupted by illness, little else was attempted. At first she was careless, imperceptive and obviously unwilling to try. Slowly she became interested, would record an unfinished game and study her mistakes, she even showed polite pleasure when she won. She was talking freely by this time and showing an independence of mind that her mother would never have believed possible.

Mrs. S. was sceptical and disgusted with the clinic when treatment was terminated with this limited objective gained, but one year later she admitted grudgingly that things were going fairly well at home and in school. Eighteen months later again, Mrs. N. wrote: '... She suffers from terrific attacks of nerves at examination time, but won't take her pills—she says they give her a headache. . . . However, despite what seems to us all evidence to the contrary, the headmistress insists that not only will Hilda be able to obtain passes at ordinary level, but should go on to the sixth form and take advanced level. Unfortunately apart from show jumping or model work she has little idea what she wants to do. The eczema on her hands and the fact that she is left handed—not to mention the examination passes required—cut out the idea of Domestic Science which she vaguely thought she might like—and though she is a great reader she does not take to the idea of becoming a librarian. Anyway, no doubt she will have to retake G.C.E. and so will stay at school for the next year. Most grown-ups think she is a charming girl. . . .' 'I am sorry to have to say that your prophesies have not come true but she *has* passed one examination—a Bronze Medal for ballroom dancing!'

It may be felt that it was just as well that Hilda's defences were of the strongest! The limited therapeutic objective of strengthening her ego to improve her effort at school and to build up some independence of her mother was justified by her eventual success at G.C.E. ordinary level and passing into an advanced level course.

AN INTENSELY OBSESSIONAL NEUROTIC DEFENCE

*Doreen S. (95)*¹

Doreen aged 13 was mute with everybody except her grandmother with whom she lived alone. Her father, to whom she had been very attached, had died suddenly two years previously. Doreen had been sent to a boarding school and her mother had returned to live with Doreen's grandmother. A fortnight after Doreen returned to the school after her first (Christmas) holidays, her mother had died suddenly. The grandmother panicked and invented a story that the mother had gone on holiday for the sake of her health, and could not write letters. Doreen made no comment, but became progressively more withdrawn. During the Easter holidays she received the news composedly and appeared to suffer little, but when she went back to school she was entirely mute. She was sent home after a few weeks and would speak only to her grandmother, with whom she was garrulous.

A year of psychotherapy achieved nothing, and the therapist was changed. At 14,

¹ Note, this case does not appear earlier in the text.

Doreen seemed to haunt the room rather than be there in the flesh. She had innumerable obsessional actions—hand washing, facial tics, touching objects, turning round as she walked, etc. Agonized expressions would pass across her face. The utmost in communication that she made was a barely perceptible nod or head shake, but only in answer to a neutrally toned question. She made endless designs in crayon that were quite frightening in their obsessive and compulsive intensity.

After 4 months, the therapist employed hypnosis in order to break the 'spell'. At the second attempt under strong pressure of hypnotic suggestion she phonated 'yes' and 'no' in answer to questions. At the fourth she told her story with great distress, haltingly and mainly by answering questions. She said that she had known intuitively of her mother's death the first time her usual letter failed to arrive; and she was relieved that her grandmother had not told her. Unfortunately, on their way to the school train, Doreen had had a violent quarrel with her mother over clothes. Doreen had stormed into the train screaming: 'I wish you were dead'; and literally never saw her mother again.

The compulsive thought had grown upon her that she had killed her mother by her words, and might kill other people too. She had a magical fantasy that her grandmother was immune from her evil tongue. Hypnotic suggestion was given that the therapist was immune likewise, and for a few minutes after coming round Doreen chatted freely. At her next twice-weekly session she was mute again and the suggestion was repeated under hypnosis with similar results.

Treatment continued for 4 months with no progress beyond a transient release immediately after hypnosis. After 10 months' treatment, Doreen would phonate 'yes' or 'no' to questions and speak in sentences about neutral matters. Anything involving emotional material still required a hypnotic trance to bring it out. Very little progress had been made, in fact.

The outbreak of war sent the therapist away on military service and abruptly terminated treatment. Two years later he received a handsome copy of *Omar Khayam* inscribed: 'With love from Doreen' in a round childish hand. She was then aged 17. It was learned that Doreen's condition was unchanged, she was still only talking to her grandmother. Her future looked bleak, indeed.

Doreen's case reveals something of the terrible force of obsessive-compulsive defences. Though Doreen could experience her feelings under hypnosis, her defences against anxiety were too strong to allow her feelings to enter consciousness. Thus they did not become related even to treatment, let alone to reality. Moreover, in the last 4 months of treatment little or no progress had been made, and there was little cause for a sanguine view of her prospects, even had continued treatment been possible.

PROFESSIONAL ROLES IN THERAPY

PSYCHIATRIST AND NON-MEDICAL PSYCHOTHERAPIST

Child psychotherapy is the province of the psychiatrist and non-medical psychotherapist. Psychotherapy is laborious and time consuming and cannot commonly be completed within less than 6 months of weekly attendances, and sometimes not within 2-3 years.

Because of pressure of consultation work and sometimes, because of inadequate training in psychotherapy, some clinic directors give the entire responsibility for treatment to the non-medical psychotherapist or to the educational psychologist. In other clinics no treatment will be undertaken. These practices may be condemned. A psychiatrist who does not undertake treatment is clinically irresponsible, he will be out of touch with his patients and will miss tremendous learning opportunities. Moreover, he will be inferior to other members of his own team in skill in the essential medical role of treatment.

The problem of the non-medical psychotherapist is quite otherwise. Psychotherapy is a highly responsible and emotionally tiring occupation involving great moral strain. It is important to vary the psychotherapist's work, and the 'extra-mural' activities of child guidance clinics provide opportunities for this.

PSYCHIATRIC SOCIAL WORKER

In the case of the majority of younger children, the visits of the mother (and less commonly the father) to the PSW are an essential part of treatment. The therapeutic technique of the PSW is a study on its own. In principle the function of the PSW is to interpret the child and the treatment process to the mother and to interpret the mother to herself. She will also keep the therapist informed, and will employ more direct social work techniques when these are relevant.

THE PSYCHOLOGIST

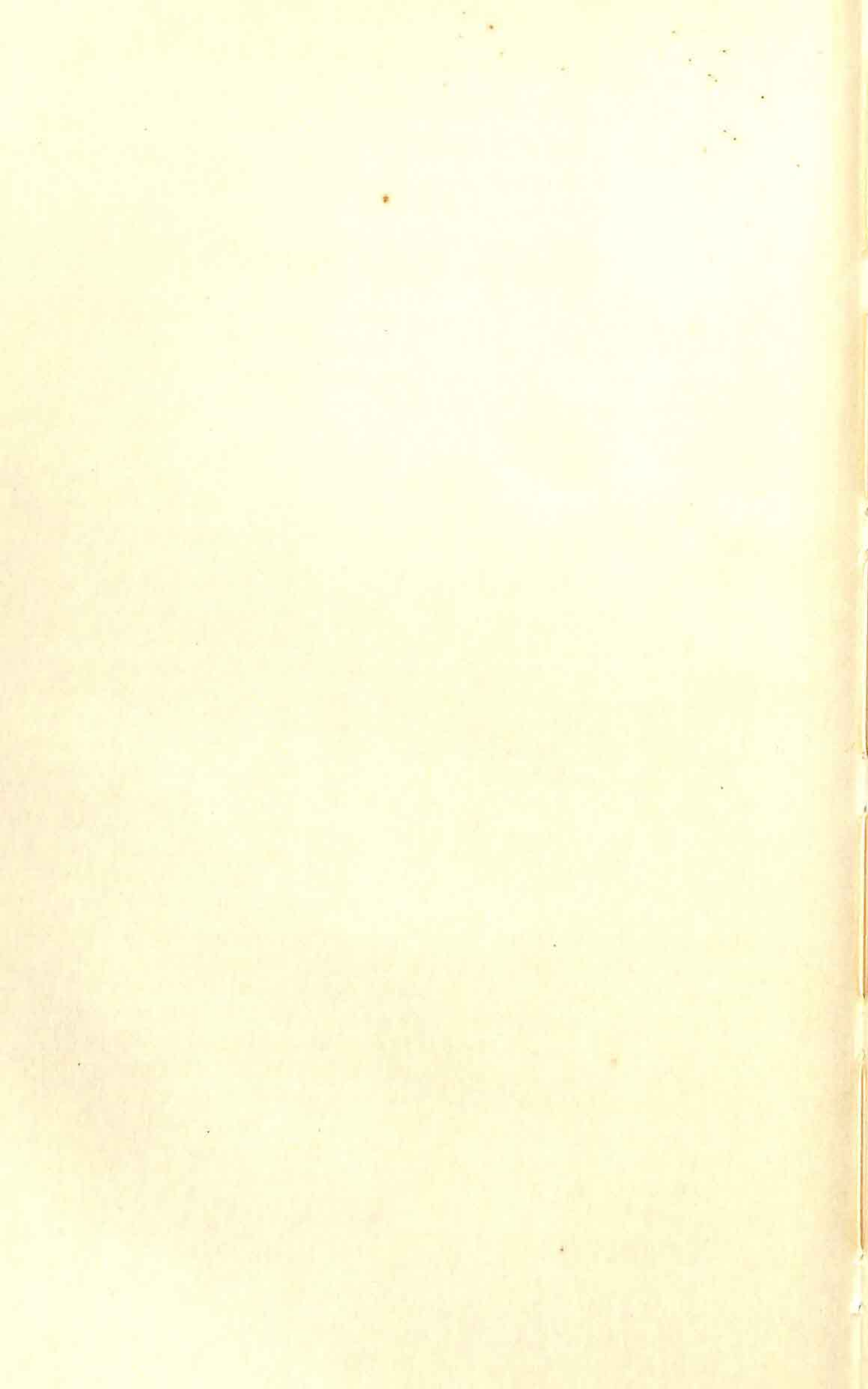
The therapeutic role of the psychologist is likewise a study on its own, but the principle specific functions of the educational psychologist in child guidance therapy are to treat the neurotic child's attitude to education and to give remedial education in basic school subjects. It is impossible to distinguish either undertaking sharply from psychotherapy.

The treatment of the child's attitude to education is illustrated by *Henry Roberts* (91) and remedial education by *Alan T.* (3). The techniques and procedures are highly specialized, and are concerned as much with the emotional as with the intellectual satisfactions of learning.

The occasional practice of making the psychologist responsible for psychotherapy is bad, unless the psychologist has been trained for this function. But there will be many cases in which remedial education will pass imperceptibly into psychotherapy, and others where the patient's need may over-ride professional qualification. Many patients have had cause to be thankful for psychotherapy given by an educational psychologist of suitable personality; and it is well to preserve a flexible attitude. Flexibility of treatment role will be more possible in a clinic in which the medical director is himself practising psychotherapy.

PART X

Preventive Mental Hygiene



Chapter 20

The Mental Health of Children

IT might be thought that there was no subject of greater importance to the community than the mental health of its children. Yet the ordinary man or woman is so afraid of mental illness that curiosity is repressed, and the whole subject—whether of illness or of health—is virtually taboo.

Public fear will contaminate almost all activities in this field. The word 'mental' is, itself, poisonous in the public mind. Even the word 'health' becomes debased in association with 'mental'. In a British House of Commons debate on the report of the Royal Commission of 1957, a Member said that mental health [*sic*] was the most serious problem facing the country; and his misuse of language passed unnoticed.

This debasement of the currency of language applies to some extent to the whole field of health and disease. The National Health Service is a euphemism for a national illness service. The notion of 'public health' will mean for many, if not most, people, quarantine for communicable diseases, meat inspection, sweet-smelling drains, and so on. 'Hygiene' popularly means body odours or even birth control.

It is natural that attention should first be fixed upon ill-health, because without knowledge of ill-health, neither prevention nor strengthening of defences can be undertaken. In child psychiatry a dynamic approach to the aetiology of illness and disorder has led to the recognition of psychologically traumatic experiences of early childhood and has contributed much to our understanding. The limitations of this approach were brilliantly exposed 25 years ago, however, and quite unscientifically by Stella Gibbons in *Cold Comfort Farm*. Grandmother, seeing 'something nasty in the wood shed', when little, dominated the entire community. Now science is catching up with satire in recognizing that the effects of trauma can be exaggerated.

Nearly all children will see 'something nasty in the wood shed' at some time, but only a few will be damaged; conceivably some may be strengthened. We are familiar with immunity and heightened resistance to infection, and with the fact that some people never catch diseases. What are the analogies to this in the psychological world? Is there such a thing as a positive state of mental health? Besides traumatic experiences, may not children, possibly, have strengthening experiences that will benefit them? If so what are these experiences and how can they be fostered, and produced artificially if they do not appear spontaneously?

ADAPTATION TO CHANGE

Time and change are extremely important conditions of childhood. Change is inherent in the child's own development; in the changing relationship between the child and its environment as growth occurs; and in the changing environment itself. It is important for health that the rate and the degree of change to which the individual is subjected should be within the adaptive capacity of the individual. This health principle is as important for the community as it is for the individual.

In Chapter 2 we have discussed the evolution of a so-called culture of change in the British cultural pattern. To go to the other extreme, it might be argued that the concept of mental health cannot exist, as such, in a rigid or unchanging cultural pattern. The concept of health—physical or mental—that is used in this discussion is incompatible with total dependence on environmental conditions. For example, the body that could maintain life only in a temperature of 65° F. and with 8 hours' sleep per day could no more be deemed healthy than the mind that demands rigid emotional and social conditions for its functioning.

The more rigid the cultural pattern, the more prescribed forms of behaviour will reach into the details of daily life, and the more conformity will go with harmony, and non-conformity with conflict. Conflict with a rigid society can be resolved only by the individual giving way, and thereby suffering distortion which, far from being a process of mental health, is one of disease or injury. If such distortion is insupportable, breakdown will occur.

Comparative studies suggest that in a culture with a more rigid framework of life there may be a standard psychosis rate, but a low neurosis or maladjustment rate. Conversely, a changing culture and one which necessitates choice between multiple alternatives may have high neurosis and maladjustment rates. But it is only possible to conceptualize varying levels and qualities of mental health in cultures that permit change or choice.

When change in society outstrips the capacity for adaptation to change of its members, rational control tends to decrease and impulsive behaviour to increase, with tendencies to snatch at chance solutions to difficulties, more or less at random. This state of community mental ill-health, as it were, can be recognized by social instability, riots, mob action, the flourishing of more extreme forms of religious and political belief, and government by repeated revolution rather than evolution. The very capacity of a community to adapt to change is a factor of its mental health, and it is important that change should arise spontaneously from within and not be identifiable with alien origins.

In the case of the individual child, change will arise spontaneously, of course, but it also will occur in the environment. It is no less harmful for the individual child than for society for change to be completely identified with

an alien origin. Change in the child must come through an existing relationship, and at a speed within the child's capacity to adapt. It is the function of the good mother to introduce change, within her loving relationship with the child, according to his capacity. This, in simplest terms, is the foundation of mental health in the infant.

An infant's healthy reaction pattern to change will include an increasing capacity for direct interaction of the child with his environment, an interaction that will eventually become independent of the mother. Without acquiring independence no child can be mentally healthy in a 'culture of change' nor can independence be gained unless there is also change and adaptation among the parents and their surrogates in society.

Thus, change in the environment co-ordinated with change in the child and at a pace to which the child can adapt will stimulate further change in the child. If this further change in the child be co-ordinated with further change in the environment, the child will be in a state of mental health. On the other hand, unco-ordinated change, change that is too rapid for the child, or change of the child in a rigid environment, will not stimulate further adaptation, but rather prevent or distort it.

In Chapter 17 *et al.* an analogy was taken from embryology, that psychological development depends upon the concurrent existence of four factors:

1. an inherited disposition;
2. a matrix of existing function;
3. material out of which the new development can form; and
4. an 'activator', i.e. an appropriate form of maternal care.

As the child develops, the 'activator' must be increasingly 'built-in' to the process of change. That is to say, the stimulation of new developments by maternal love and appreciation must be replaced by inherent satisfaction in the development itself.

So another basic principle of mental health emerges: there must be a continuously adjusting balance between drives and satisfactions. This principle holds at the extremes of human experience; as much for the infant crying for a breastful of milk as for the prisoner awaiting martyrdom for his Cause. The difference between these examples lies in the nature of the satisfactions, which will be derived from the individual's hierarchy of values.

The dynamic balance necessary for mental health will include the balance both of conative and of cognitive development, and the harmonization of these.

CONATIVE BALANCE

Emotional maturation depends upon the modification of the primitive erotic drives of babies towards immediate bodily satisfaction, their control, and the substitution and sublimation of objectives. So long as the drives remain unmodified, the emotional relationships remain infantile. Healthily modified

instinctual drives will, at all stages of evolution, be contained within the child's developing system of external interpersonal relationships. True satisfaction will be found in individual and group relationships.

These relationship satisfactions will, subject to the individual's capacity for abstractions, include abstract concepts of the community, of humanity, of divinity; but, whether concrete or abstract, the harmonization of erotic satisfaction within the relationship system is essential for health.

COGNITIVE BALANCE

The role of cognition in the development of childhood relationship systems has been discussed in Chapter 9. In regard to mental health, the important cognitive development of late infancy and the toddler period is the identification of self in its interdependence with the environment. To come to know oneself is necessary for individual development; and to come to know other people, both in themselves and in relation to oneself, is necessary for social adaptation.

To know oneself is to recognize one's own drives—feelings, aggressiveness, passions, needs, capacity to love and so on; and to know other people is to recognize these things in other people, too. But maturation will lead to the recognition of the need to control and to utilize these drives, and into knowing how this can be done. Perhaps only the more in-turning people will gain a full conscious recognition of these matters, but cognition operates also at levels below consciousness.

HARMONIZATION OF CONATION AND COGNITION

Healthy modification of instinctual drives will result in the harmonization of feeling and thought, so that control of aggressivity and sublimation of instinctual drives will be free from tensions of anxiety and guilt. This will promote strong identity formation, without which ego-strength will not be sufficient to support the moral pressure of a strong super-ego; so that the harmonization of conation and cognition is vitally important.

In *Escape from Freedom*, Erich Fromm has suggested that without self-love it is not possible to love others. The corollary is that self-love begets the capacity to love others; but it will be generally accepted, too, that self-hatred begets hatred of others. That fear of self leads to fear of others and anxiety for the self to anxiety on behalf of others is a commonplace of clinical experience. The self-hating mother may believe her baby to be a monster; or her school-child a delinquent or a failure. The rejecting mother who compensates by possessiveness may fantasy in her child's dalliance on the way home from school, a thousand road accidents or encounters with 'the man with the staring eyes'.

Mental health will derive from the harmonization of conation and cognition, and of self-love and love of other people that will lead parents to

delight in their children, to expect the best but not demand the impossible, to repose confidence in them.

PRACTICAL MENTAL HYGIENE MEASURES

In mental health work nothing succeeds like success and nothing fails like failure. The great difficulty is that preventive work must necessarily start from a position of weakness, from troubles caused by the mental health failures or weakness of people.

Many types of preventive activity are undertaken: marriage preparation; antenatal, maternity and child welfare services; child guidance; special educational measures; youth clubs and movements; social welfare activities of all kinds. Even geriatric services are advocated, to remove foci of tension in families. These necessary activities help in the prevention of mental illness and maladjustment, but they do not represent a truly positive approach to mental hygiene.

The difficulty about making practical mental hygiene proposals is that recommendations must apply to quite specific situations. Perhaps the basic necessity is that child-rearing practices should be appropriate to the culture. In Britain, with its rapidly changing communities, qualities of independence and adaptability will be highly prized; qualities which depend for their development on a high degree of basic security in infancy. An intimate loving relationship between child and mother will give the best chance of harmonious adjustment to the continuous learning of early childhood. The small biological family unit provides that discipline within intimate loving relationships which makes for independence of character; whereas discipline in a remote system of relationships leaves the individual dependent upon the institution of the joint family.

Young parents will be likely to produce the most adaptable children; but the great shortcoming of the basic nuclear family is vulnerability should anything untoward happen to the mother, or if she is unsuitable. Therefore, in the 'culture of change', social services to protect the children of broken families will contribute positively to the mental health of the community. This need is less a weakness of the culture, than a disadvantage inherent in its strength. The extended family does not often break down, but it does not render its children so adaptable, because when, as sometimes if not generally happens, its intimate relationships are weaker, the emotional satisfactions to be derived from change and adaptation are weaker also.

British families commonly experience difficulty with the toddler's learning experiences, when the mother's dilemma will be between her maternal urge to control her child and the child's need to gain experience for himself in a complicated and difficult world. The moral basis of the usual British upbringing, the limitations of flexibility in a culture that is continuously evolving within a main tradition, and the complications of the environment make

be to supervise the employment of young people in unskilled occupations. The unskilled youth or girl in the factory, the 'tea boy' on the building site, or the runner or messenger can be subject to demoralizing influences that may be countered by giving the children adequate outlets for physical energy and some visible share in a creative process.

In conclusion, it may be re-emphasized that the attitude of society to its youth, and vice versa, is determined by the childhood experiences of individuals. Security in basic emotional relationships will resolve the individual's childhood interpersonal relationships situations, and enable him to progress towards a maturity in which he will conduct his relationships with the next generation free from the jealousy of youth that springs from insecurity. On the other hand, unresolved infantile insecurity or oedipal conflict will tend to rise to a climax of intensity during adolescence that will make the young react particularly badly to unfavourable attitudes among their elders at this period. There are possibilities here, therefore, of a very vicious circle. So, in the end, the positive establishment of mental health depends upon basic security in infancy, the smooth modification of instinctual drives enabling the organization of perceptual experiences, and opportunities to learn by trial in an environment that protects from harmful effects of inexperience, without reducing opportunities. A certain degree of stress is essential for development to occur, but stress beyond the capacity of the child to bear it will impair or possibly prevent development. Finally, mental health will depend upon a continuously adjusting balance being maintained, both within the individual and between the individual and his human environment.

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